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Presented by: Carlos García-García

Directed by:

Prof. Dr. Ester Barberá Heredia

Prof. Dr. Joan B. Llinares Chover

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To Tana

THANK YOU

This research stems from my concern, as a clinical psychologist and psychotherapist, to find answers to essential questions and to establish the limits and possibilities of my profession. I thank all those professionals in psychiatry and psychology whose works have inspired me and who, with courage and rigor, denounce the dogmatism, reductionism and authoritarianism unfortunately present in our disciplines. With equal emphasis, I thank the patients for teaching me what I know about this exciting work. I would also like to sincerely thank the following people for their support:

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INDEX

Introduction 9

PART ONE. LIFE AND WORK OF THOMAS S. SZASZ

1. Biographical notes 29

1.1 From Budapest to Syracuse (1920-1955) 29

1.2. The first years as a teacher. The "Szasz case" (1956-1962) 40

1.3. A life committed to the cause of freedom (1963-2012) 55

2. System of thought 61

2.1. Szasz, philosopher of psychiatry 71

2.1.1. What is mental illness? 75

2.1.2. What kind of science is psychiatry? 85

2.1.3. Should psychiatry follow a medical model? 91

2.2. Szasz, liberal politician and abolitionist of psychiatry 104

2.2.1. Szasz's radical liberalism 104

2.2.2. For the Abolition of Coercive Psychiatry 111

2.3. Szasz, behavioral and psychoanalytic theorist 119

2.3.1. Human behavior according to Szasz 119

2.3.2. The ethics of psychoanalysis according to Szasz 126

PART TWO. THOMAS S. SZASZ AND THE CRITICS OF PSYCHIATRY.

3. Szasz, antipsychiatry and postpsychiatry 141

3.1. History of antipsychiatry 144

3.1.1. What was antipsychiatry? 144

3.1.2. Who were the anti-psychiatrists (and who were not)? 147

3.2. Szasz's criticisms of anti-psychiatry 167

3.3. Postpsychiatry, a new antipsychiatry? 175

4. Szasz and critical psychiatry 185

4.1. Fundamentals of critical psychiatry 185

4.2. The theories of three critical psychiatrists 200

4.2.1. David Ingleby's critique of psychiatric positivism. 200

4.2.2. The epistemology of psychiatry according to Germán Berrios 206

4.2.3. The Allen Frances trial of the diagnostic system and psychiatric and psychopharmacological treatment. 214

4.3. Szasz and the critical psychiatrists. A brief comparative study 221

5. Szasz's fundamental errors, a personal opinion and a proposal 231

5.1. A Theoretical Error: Trivializing Psychosis 231

5.2. A policy mistake: Abolishing institutional psychiatry 241

5.3. Medicine, psychiatry and psychology. The training of clinicians 246

Conclusion 257

Annex I. Complete Works of Thomas S. Szasz 263

Annex II. Books by Thomas S. Szasz 311

Bibliography 315

INTRODUCTION

Ever since psychiatry[1]was born in the 19th century, a battle has been waged regarding its epistemological foundations, the nature of its object of study and the principles that should guide its practice. Some of the first psychiatrists, such as Emil Kraepelin, understood that psychiatry should be a branch of medicine because they considered that its object, which they called "mental illness", was an illness like any other. They defended the biological causality of psychic disorders, established a classification of these disorders according to the symptoms observed (behaviors, ideas, manifestations of feelings, etc.) and applied physical therapies to patients, generally involuntarily committed to asylums. Others, such as Sigmund Freud, questioned whether such disorders had the same quality as physical illnesses and, on the contrary, believed that their origin was psychological. They proposed a diagnostic classification based not so much on symptoms as on the psychic structures of the patients (neurosis, psychosis and perversion) and therapy was exercised in the private sphere by means of speech. In short, in the first (medical) model, observation and classification of objects (symptoms) prevailed, and in the second (psychological) model, listening and interpretation of the subject's personal experiences prevailed.

[1]In this paper, when referring to psychiatry, reference is also made, in general, to clinical psychology. The difference between the two professions is basically that psychiatrists have studied medicine and can prescribe medication, whereas clinical psychologists have studied psychology and are not authorized to do so. Beyond this, in Spain, psychiatrists and clinical psychologists are equally entitled to practice psychotherapy in both private and public settings. On occasion, both psychiatrists and clinical psychologists will be referred to as "clinicians".

In view of the above, psychiatry proves to be a very particular science[2]as its practitioners do not agree on what is its object of research or on the appropriate ways to practice clinical work. This multiplicity of theoretical perspectives and practical interventions necessarily raises questions about the epistemological and conceptual foundations of this discipline. The main representatives of both trends wanted to shut down the discussions by appealing, as if they were religious leaders, to a faith without proof: the truth was in the brain, in the unconscious, etc. Few were the psychiatrists who maintained a non-dogmatic, critical and sensitive position to conceptual and epistemological problems. In any case, there was always greater self-criticism among the representatives of the subjectivist orientation than among those of the objectivist one since the latter, covered by the mantle of *scientific truth*, has appeared to be more solid conceptually. We find an example of this critical stance towards the discipline itself in the words of the renowned psychoanalyst Harry Stack Sullivan on what he called "the subjectivist".

[2]In this essay, the sciences will be classified following the approach of Luque and Villagrán (2000, pp. 81-82): "Western philosophy in this [20th] century has contemplated two traditions that have influenced the vision of psychiatry: on the one hand, the tradition of *analytic philosophy*, typical of the Anglo-Saxon world, with its emphasis on the analysis of language as a means of objectifying scientific discourse; on the other hand, the Central European *hermeneutic*, phenomenological and existential tradition, which emphasizes the subjective aspects of human existence and how these influence science. Within the hermeneutic tradition, but in its more epistemological aspect, the distinction between the natural sciences and the sciences of the spirit [here I will also call them humanities or social sciences] arises, as proposed by Dilthey. While the former would include disciplines such as biology, physics and chemistry, would use observation as their method and seek explanation through *causes*, the sciences of the spirit (sociology, history, anthropology and psychology) would seek to understand *reasons* through empathy. These would therefore be *first-person* sciences that would primarily use the study of the individual case (*idiographic* sciences for Windelband) while the former would be *third-person* disciplines that would seek generalizations (*nomothetic* sciences for Windelband)."

unconscious. Although this author refers to the theory created by Freud, substitute in the following quote "psychoanalysis" for "biological psychiatry" and "unconscious" for "neurotransmitter" or any other object or circumstance considered causal, and the conclusion will be identical:

> It is difficult to build a science [alluding to psychoanalysis] when there are gaps between things. Who knows what is in the gaps? [...] The unconscious is that which cannot be directly experienced, that which fills all the gaps of mental life. [...] Let no one be tempted to go out into the world talking about the unconscious, because it is almost certain that someone will ask him how he came to know it. [...] One proceeds to saturate the unconscious (that entity which is not susceptible of direct experience) with reasonable irrationalities and irrational reasonings, and so on, and thereby, to my mind, one becomes magnificently and completely a clown (Sullivan, 1968, pp. 310-312).[3]

Historically, the two paradigms mentioned above, the medical and the psychoanalytical,[4]with their different versions (much more numerous and diverse in the latter, with

[3]Note on quotations and translations: In order to make the reading of this work more fluent, I will translate into Spanish any literal quotation of less than 40 words written in another language. Only quotations exceeding 40 words that do not have a Spanish edition will appear in their original language (English or French). If there is one, I will use this translation, revising and altering it when, in my opinion, it deviates from what is stated in the originals. Only the quotations from the original texts of Szasz, as main author, will be those with a footnote translation.

[4]I will refer to the "medical" (or "biomedical") model in the same sense as Héctor González and Marino Pérez, as opposed to the "contextual" (or "psychosocial") model: "The *medical model* of psychological therapy conceives mental disorder as a picture of symptoms corresponding to a supposedly dysfunctional internal psychological mechanism (equivalent to the biological condition assumed by the medical model of disease). Thus, psychological therapy would consist of the application of specific techniques, which would be

successive modalities of psychotherapy), have alternated their hegemony in university training, clinical practice and institutional power. However, from the 1980s onwards, the thesis of biological causality and medical treatments began to rapidly gain ground over psychosocial theories. Neuroscientific research provided, through genetic studies and neuroimaging techniques, empirical data that (supposedly) supported the correlation between certain biological markers and behaviors diagnosed as mental illness. Medical psychiatry thus proclaimed itself the definitive bearer of a *truth* that was assumed to be unquestionable: the mind is the brain. Under this banner, there was a boom in the use of psychotropic drugs that replaced the old physico-chemical therapies (such as lobotomy, electroshock or insulin or cardiazole *shocks*), diagnostic manuals (*DSM-III* and its subsequent versions), clinical guidelines and lists of empirically validated treatments. This positivist roadmap, called "evidence-based psychiatry" (EBP), has almost completely colonized the University to the detriment of other models.[5]The students

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equivalent to medication (when such specificity does not exist either in psychopharmacology or in psychotherapy). On the other hand, the *contextual model* of psychological therapy understands the problem presented (which does not need to be identified as a 'mental disorder' or a symptom picture) in the biographical context of the person and his or her circumstances. Thus, psychological therapy would consist more than anything else in the provision of help given in the context of an interpersonal relationship, one would be excused for saying that professionally conceived" (González Pardo and Pérez Álvarez, 2008, pp. 18-19). Schematically, it could be pointed out that in the medical model symptom (object) is located, a specific diagnosis is issued and the corresponding treatment (technique and/or medication) is prescribed, and in the contextual model the psychological structure and social context of the person (subject) is analyzed, a specific and closed diagnosis is not required, and the treatment is based on the therapeutic relationship through words. Thus, in the medical model, the gaze prevails and in the contextual model, listening.

[5]Psychiatrist, neurologist and philosopher Germán Berrios states that: "Psychiatrists are asked to accept EBP without any evidence other than the moral extortion created by claims that mathematics is the ultimate expression of science and, , that which is 'mathematically

of psychiatry were trained exclusively in the biomedical model and those of psychology in the so-called scientific or experimental psychology.[(6)] "Empirical" became a synonym for

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demonstrable' should be above all else. Never has an EBP advocate explained why a large-scale trial designed to demonstrate that prescribing and therapeutic decision making based solely on EBP is significantly better than decision making based on the wisdom and experience of physicians" (Berrios, 2011, p. 308).

[6]In 1952, the *American Psychiatric Association* published the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-I*), which described 106 diagnoses of mental disorders. The fifth edition of the manual, *DSM-5*, recently published (May 2013), already includes some 400 diagnostic references. The progressive increase in the number of behaviors listed in what is known as "the psychiatric bible" and the significant decrease in the thresholds for what is considered "deviant from the norm" behavior, is causing the rate of the population susceptible to being classified as "disordered" and, consequently, to be treated to soar.

Moreover, since the authorization of chlorpromazine for psychiatric use in 1954, the prescription of psychotropic drugs has become, in rapid progression, the standard practice not only of psychiatrists but also of primary care physicians who are frequently subjected to commercial pressures. The reference manual used by psychiatrists and psychologists when diagnosing mental disorders is the *DSM*, which is sponsored by large pharmaceutical corporations. There is a well-founded suspicion that those who encourage the creation of new psychiatric disorders and the expansion of existing ones have the "remedy" in advance, a perverse strategy that brings them great economic benefits.

Since 1996, Division 12 of the *American Psychological* Association periodically publishes a list of "empirically validated treatments" (2006), of which a very high percentage corresponds to pharmacological treatments and those of behavioral or cognitive-behavioral orientation, psychotherapies that represent the self-styled "scientific psychology". This list, which disregards the practice of a multitude of psychotherapists who do not agree with "scientific" therapies, responds to the following dominant ideology in psychology: "There is only one acceptable clinical psychology, that which is based on the principles of the scientific method. As a consequence, psychological services will be administered to patients when they have demonstrated their validity by means of planned scientific tests" (Llobell, Frías & Monterde, 2004,

The term "true", "undoubted", "good", "reliable", etc. and any non-empirical approach was considered non-scientific and, , false. However, as the scientistic euphoria grew, some voices critical of the medical model emerged within psychiatry and psychology (e.g. Ingleby (Ed.), 1982; Miller and Rose, 1986) who questioned the scientific validity and the political and practical consequences of this paradigm. This trend evolved slowly until the beginning of this century, when a growing number of papers have begun to be published that, using the same scientific criteria as biological researchers and conducting a serious conceptual and epistemological analysis of psychiatry, have questioned the validity of neuroscientific research and its results, the efficacy of psychotropic drugs, and the lack of scientific rigor with which diagnostic classification systems are established and therapies endorsed by EBP are selected. These works have also revealed the perverse political-economic alliances between States, psychiatry and pharmaceutical companies that have promoted diagnostic inflation and the massive and indiscriminate prescription of psychotropic drugs. This critical thinking has been gaining followers among psychiatrists and clinical psychologists, giving rise to a trend that can be called

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p. 7). One of the leading advocates of "empirically validated treatments" is psychology professor Dianne Chambless (Chambless and Hollon, 1998; Chambless and Ollendick, 2001).

Finally, the university training of future psychiatrists and psychologists is dominated by the same ideology. In fact, at least in Spain, those high school students who wish to study medicine or psychology are recommended to choose the Health Sciences branch, structured around the subjects of chemistry, mathematics and biology. Once in the faculties of psychology and medicine, future clinicians will find no trace of the subjects of the human and social sciences, but only of the natural and exact sciences.

"critical psychiatry" in recognition of the book that I consider the founder of this trend: *Critical psychiatry. The politics mental health* (Ingleby (Ed.), 1982).[7].

More and more researchers and professionals in psychiatry and psychology are rebelling against the scientistic authoritarianism (Peteiro, 2010) present in their disciplines:

> It seems that the offer made to us is: "assume my vision of man, of his problems ('psychopathologies'), of the therapist, of science and, reasoning with my own arguments, demonstrate the efficacy of your treatment model [...]. I start the game, and I also set the rules that interest me, the first of which is that no one can refrain from playing". Well, there is no reason to accept a game under these conditions (Rodríguez Morejón, 2004, p. 7).

Critical psychiatrists strongly oppose the reductionism of the biomedical model and EBP (and also that of any other paradigm) and defend the need to permanently question the foundations and practices of psychiatry, to the point of affirming that "nothing can be considered sacred, even the idea that psychiatry should be a branch of medicine" (Berrios, 2011, p. xiii). They consider that, in any case, psychiatry would be a hybrid discipline since its object, mental disorders and symptoms, have links with both the natural sciences (they do not deny the possible influence of brain processes on behavior) and the humanities (since what counts in clinical practice is to understand the way in which each person lives and interprets his or her life) (*Op.cit.*, 2011). This double epistemological affiliation, in which the humanities would prevail because they are the sciences with the greatest descriptive and comprehensive potential for the

[7]Perhaps, not all the authors included in this denomination would agree to call themselves this way. If I use this name, it is only for practical purposes.

subjective experiences, would force the clinician to be trained not only in anatomy, physiology and biochemistry but, perhaps with greater emphasis, in disciplines such as philosophy, linguistics or sociology.

On the other hand, critical psychiatrists demonstrate that psychiatrists' decisions (diagnoses and treatments), unlike those of other physicians, are more conditioned by their personal values and interests than by scientific criteria, that psychiatric research and practice are excessively influenced by commercial interests, and that institutional psychiatry frequently exercises a function of social control by coercive means (Cf. Frances, 2014).

As in the rest of the world, in Spain more and more professionals and researchers are joining this trend critical of scientistic psychiatry and psychology:

> The present psychiatry is radically uneducated. [...] There is no longer any intention to link the ideas of psychiatry with the notions coming from the rest of the human sciences: psychoanalysis, anthropology, linguistics, history, literature or philosophy. Psychiatry, after its espousals with scientific positivism, has turned its back on the desire to know about madness, burying curiosity and scorning intelligence (Colina, 2012, p. 11).

> The prevailing psychiatric discourse of our days, [...] in spite of its apparent scientistic garb, is still an impoverishing and fearful discourse, on the one hand excessively influenced by the latest technological discovery, on the other hand immobile and stubborn in the face of the evidence of the most clamorous inadequacies (Luque and Villagrán (Eds.), 2000, p. 11).

> The biomedical model has a paternalistic background that attributes most of the task of solving the mental problem to the professional and where the patient's role is relegated to accepting the interventions. This dynamic favors the use of coercion in certain circumstances. Likewise, the technological paradigm that makes psychiatric interventions scientific, makes it difficult to analyze them critically, even when their side effects are serious and the risk/benefit margin is narrow or non-existent. Finally, psychiatry has acquired in recent years a social preeminence that favors the medicalization of many problems of daily life and the exposure of more citizens to inadequate, inappropriate or excessive interventions (Ortiz Lobo, 2013, pp. 17-18).

> What is emphasized on all sides is that "mental disorders", far from being supposedly *natural* entities with a biological basis [...] would be *constructed* entities of a social-historical nature, more subject to the ups and downs of life than to the imbalances of neurochemistry. The fact that they are constructed entities does not deprive disorders of their real entity. However, their letter of reality would be of another order, more of the order of the problems of life than of biology and of the person than of the brain (González Pardo and Pérez Álvarez, 2008, pp. 13-14).

The main contributions of today's critical psychiatrists can be grouped into three areas: (a) on the theoretical level, they promote a constant analysis of the conceptual and epistemological (historical and philosophical) foundations of psychiatry in opposition to the reductionism of the biomedical model (also that of the psychoanalytic model or that of any other paradigm) and of evidence-based psychiatry and advocate a broad training of psychiatrists that includes the humanities; b) on the political level, they unveil the web of interests underlying the relationship between psychiatry and pharmaceutical companies (epitomized in diagnostic inflation and the alarming increase in pharmacological treatments) and criticize psychiatric coercion of the freedom of individuals; and, c) on the political level, they criticize psychiatrists' coercion of the freedom of individuals; and, d) on the political level, they criticize psychiatric coercion of the freedom of individuals; and, e) on the political level, they criticize psychiatrists' coercion of the freedom of individuals.

on the practical level, they are committed to a clinic that takes greater account of the contexts and particularities of the subject and that recognizes the relationship between the clinician and the patient as a crucial therapeutic element (Thomas, 2013).

This research is a contribution to this change, not of paradigm (since critical psychiatry should not be understood as a set of beliefs, theories and practices but as a current of thought that, precisely, questions any model of psychiatry presented as dogmatic truth) but of thought and attitude, oriented to psychiatrists and clinical psychologists assuming the limits and real potential of their discipline and exercising a permanent questioning of the theory that allows a practice far from uncritical and untouchable preconceptions.

Thomas S. Szasz, forerunner critical psychiatry

The first author to raise such criticisms systematically was Thomas Szasz, who, in 1961, published a book that questioned the principles on which, up to that time, institutional psychiatry and psychoanalysis had been based: *The Myth of Mental Illness*. However, a review of the literature of critical psychiatry shows that Szasz is hardly mentioned. This paper will consider the reasons for this absence.

Thomas S. Szasz (1920-2012) was a professor in the department of psychiatry at *the State University of New York* (S.U.N.Y.) in Syracuse (USA) and a prolific author known worldwide for his relentless critique of psychiatric power, the concept of mental illness, the scientific status of psychiatry, and the medical model applied to psychotherapy.

He was also known for his defense of individual liberties on issues such as the confinement and involuntary treatment of the so-called mentally ill, drug use, homosexuality and suicide, among others. On the other hand, he belonged to numerous professional and social organizations and received dozens of national and international recognitions for his academic work and in defense of civil liberties.[8]Despite the extension and variety of his production (35 books and hundreds of articles and interventions) developed during more than 60 years, Szasz is known, mainly, for his liberal political side as an abolitionist of institutional psychiatry. His political activity against psychiatric power brought him popular *recognition* as the "father of anti-psychiatry", a stigma that marked him for life. However, Szasz always denied this affiliation and, even more, harshly criticized the postulates of the founders of this movement, Ronald Laing and David Cooper. I believe that the unfortunate brand of anti-psychiatry has negatively conditioned the interpretation of Szasz's figure and the reading of his work. One of the purposes of this thesis is to combat this prejudice by demonstrating that, contrary to what is often said, Szasz was never an anti-psychiatrist.

Although hundreds of articles were written for and against Szasz's theses, he is virtually unknown today, as psychiatry professor John Sadler states: "When I was a resident [in psychiatry in the 1980s], everyone knew who Szasz was, but psychiatry students in the last twenty years never heard of him" (Mitchell, 2009). This is not only confirmed by advocates of biological psychiatry such as Thomas G. Gutheil, who states that "simply put, Dr. Szasz is no longer

[8]For further information on the merits of Thomas Szasz, see the first chapter of this thesis, "Biographical notes" and his *curriculum vitae* at http://www.szasz.com/cv.pdf.

is " (Schaler (Ed.), 2005, pp. XXIII-XXIV), but by the critical psychiatrists themselves who hardly mention it and, if they do, it is only briefly and as a radical anti-psychiatrist.

It is not surprising, therefore, that Szasz has not aroused much interest among Spanish academics either, with the exception of the philosophers Antonio Escohotado and Fernando Savater.[9] I am not aware of any research on his work in Spain, and abroad I have only found five doctoral theses in which his name appears in the title,[10] which contrasts with the magnitude and, in my opinion, the value of his intellectual legacy. I intend to present, with sufficient breadth, Thomas Szasz's system of thought and to vindicate its importance in the history of critical psychiatry.

In his early books and articles (1956-1965), Szasz already addresses the three strands in which, as I have pointed out, the current criticisms of psychiatry are posed:

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[9]The main introducers and supporters of Szasz in Spain have been the philosophers Antonio Escohotado, translator of three of his books (*Droga y ritual*, *La teología de la medicina* and *Nuestro derecho a las drogas*) and prologist of the Spanish edition of *El mito de la enfermedad mental* that I use here, and Fernando Savater, prologist of *El segundo pecado* and author of press articles on Szasz such as, for example, "El año Szasz" (*El País*, January 10, 1985): http://elpais.com/diario/1985/01/10/opinion/474159607_850215.html.

[10]Pols, J. (1984). *Mythe en macht. On the critical psychiatry of Thomas S. Szasz. University of Groningen* (Netherlands); Latulippe, M. (1996). *Conflits et psychiatrie chez Thomas S. Szasz. Université Laval* (Canada); Vice, J. A. (1998). *From patients to persons: The psychiatric critiques of Thomas Szasz, Peter Sedgwick and R. D. Laing. Vanderbilt University* (USA); Maciel, R. R. (1999). *Contestação e construção do saber psiquiatrico: uma interpretação da obra de Thomas S. Szasz. Universidade Estadual de Campinas* (Brazil); Olsen, J. and Andersen, T. (2015). *Om at forstå psykiatri i forhold til Thomas Szasz. Roskilde University* (Denmark). Sources: Open Access Theses and Dissertations (http://oatd.org), ProQuest Dissertations & Theses Database (http://www.proquest.com/products-services/pqdt.html), and Networked Digital Library of Theses and Dissertations (http://www.ndltd.org).

1. Conceptual and epistemological critique. According to Szasz, psychiatrists invented the term "mental illness" seeking social recognition as physicians and scientists. They considered that their function, as scientists, was to discover the biological origin of mental illness and, as physicians, to cure it. Their inability to prove, by scientific methods, the objective existence of such an illness, indicates that there is nothing and no one that can be cured in the medical sense of the term. Therefore, as long as the existence of mental illness is not proven, psychiatry should not be considered a medical or natural-scientific discipline. If the term "mental illness" lacks scientific evidence, it can only be considered a popularly agreed-upon linguistic resource to describe certain behaviors of individuals that deviate from the expected norm, which refers, in any case, to ethical and not medical issues. If this were true, psychiatry would not be linked to the natural sciences but to the humanities and social sciences.

2. Political criticism. Szasz defined himself as a liberal. He strongly opposed any institution or ideology that threatened the values of freedom and individual responsibility, specifically what he called *the therapeutic state*[11]or the alliance between the state and psychiatry as an institution of social control and coercion. By virtue of this alliance, psychiatrists have performed social functions very different from those of other physicians, such as, for example, determining, on the basis of their opinion of the mental state of a patient, whether or not he or she is in a state of mind,

whether or not he or she has a mental disorder.

[11]The popular concept of the "Therapeutic State" was coined by Szasz in 1963, in his third book *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (Szasz, 1968): "Although we may not know it, we have witnessed, in our time, the birth of the Therapeutic State" (*Op. cit.*, p. 212). See also *The Therapeutic State: Psychiatry in the Mirror of Current Events* (Szasz, 1984b). Another coined by Szasz, which derives from the previous one, is "Pharmacracy," which appeared in *Drug and Ritual* (Szasz, 1974) and was expanded in *Pharmacracy: Medicine and Politics in America* (Szasz, 2001).

The individual, whether he or she is or is not responsible for a crime and, on that basis, to order internment and treatment against the will of the person arbitrarily stigmatized as mentally ill, or, on the contrary, to excuse such behavior by alleging mental derangement. Szasz considers that such coercive or exculpatory practices, in any case paternalistic, represent an attack on the rights and freedoms of citizens.

3. Critique of clinical practice. According to Szasz, mental illness is nothing but a metaphor commonly used to designate those problems of an ethical nature that concern people's way of living and their choices as moral agents of their existence. *Problems in life*[12]are not diseases at all but behaviors that require a psychosocial intervention (psychotherapy) more akin to moral education than to a cure. Therefore, the application of medical diagnoses and therapies for such behaviors is unfounded. He considers that the so-called mental illnesses are more similar to languages (intentional communication by means of signs) than to organic diseases. Thus, in psychotherapy it will not be useful to investigate the etiology of language, as if it were an illness, but rather to understand the language used by the subject (but which, however, he does not know), as communicative behavior, as well as the intention with which it is used and the context in which it is produced. In contrast to the biological conception of human behavior (mind-brain analogy), based on the natural sciences, Szasz proposes a linguistic, sociological and philosophical analysis of the same. , the ethical commitment of the psychotherapist should not consist of caring or curing, but rather in

[12]Szasz borrows this term from H.S. Sullivan to replace the more stigmatizing terms "mental illness" or "psychological disorder".

in "unraveling the play of life in which the patient participates" (Szasz, 1961b, p. 58). According to Szasz, the psychotherapist should be a professional committed to the ethics of individualism, not a healer dedicated to the ethics of care. He advocates what he calls "autonomous psychotherapy", as an enterprise regulated by a contract based on the active commitment and responsibility of the actors with respect to an ultimate goal: increasing the client's autonomy and responsibility as conditions for obtaining a greater degree of freedom.

Let the above serve as an indication that the arguments of the current representatives of critical psychiatry could already be found in Szasz, namely: the rigorous questioning of the scientific impostures of biomedical psychiatry and its coercive practices; the defense of a new conceptualization of psychopathology different from the medical diagnostic classifications; the proposal of an epistemological revision of psychiatry based its historical and philosophical foundations; and the need for a training plan for clinicians that includes not only the natural sciences but also the humanities.

Object of study and structure of the thesis

As mentioned above, this theoretical work aims to fill the existing gap in knowledge about the work of Thomas Szasz. On the other hand, the thesis I defend is that this author should be recognized as a precursor and a main referent of the so-called critical psychiatry.

The extent and quality of Thomas Szasz's work and his important, although not always recognized, contributions to the field of the philosophy of psychiatry are, in my opinion, reasons that, together with the novelty of presenting this author in the Spanish university, justify and make this doctoral thesis relevant. Who was Thomas Szasz, why his figure and his work are important for current critical psychiatry and what are the reasons why he lacks this recognition are the fundamental questions that this research will try to answer.

The work is divided into two parts. The first, consisting of two chapters, has an expository character and is devoted to presenting the figure and work of Szasz. The second, consisting of three chapters, has a demonstrative character and aims, on the one hand, to analyze the relationship between Szasz's thought and that of other critics of psychiatry and, on the other hand, to present my particular criticism of Szasz and to put forward a formative proposal for psychiatry.

In the first chapter I will review Szasz's biography, as I consider it inseparable from his political and intellectual work, paying special attention to the events of the early 1960s in the university department of psychiatry where Szasz was a professor. Because of his criticism of the conceptual, epistemological, practical and political principles of American institutional psychiatry, he was forbidden to continue training resident physicians at the psychiatric hospital attached to his university. These events, called "the Szasz case" (Schaler (Ed.), 2005), were the best example of what Szasz wanted to demonstrate: that psychiatry acted as an institution that repressed individual liberties. The cornering that Szasz suffered at the university and the dismissal of the professors who supported his ideas marked both the end of his academic project, the multidisciplinary training of psychiatrists and clinical psychologists, and the beginning of the power of the

biological psychiatry and the self-styled scientific psychology that today, fifty years later, reigns in universities all over the world. The documents consulted in this section will be Szasz's autobiography, his testimonies in different interviews and several articles by other authors referring to his life.

In the second chapter I will present Szasz's system of thought in the three strands in which critiques of psychiatry have traditionally manifested themselves: a) the philosophical (conceptual and epistemological) analysis, structured around the three questions that are usually asked in this regard: what is mental illness? What kind of science is psychiatry? and Should psychiatry follow a medical model? b) the critique of the coercive practices of psychiatry, where Szasz's liberal principles will be presented; and c) the clinical practice, where Szasz's theories on the foundations of human behavior and on psychotherapy will be shown. Szasz's main texts will be studied from the time he began his critical work in 1956 (the year in which he took up his teaching position at the university) until his death in 2012, as well as what he expressed in various interviews. This will provide a broad view of his thinking and show that he never renounced or modified his initial convictions.

In the third chapter I will try to show that Szasz was never an antipsychiatrist. To do so, I will review the history of antipsychiatry in order to clarify what this movement consisted of and who deserves the appellation of antipsychiatrist. Szasz's criticisms of antipsychiatry will also be presented and, finally, a description will be given of a current movement that may evoke, with nuances, that of antipsychiatry: postpsychiatry.

In fourth chapter I will defend the fundamental thesis of this research, , that Szasz was a precursor of critical psychiatry. After exposing the foundations of this trend from the writings of several of its main representatives, a comparative study of Szasz's texts on the philosophy of psychiatry with those of some of those such as David Ingleby, German Berrios and Allen Frances will be carried out.

In the fifth and last chapter, I will try to clarify the reasons why I consider that these authors disagree with Szasz. In relation to this, I will expose the two errors that, in my opinion, Szasz made and that could justify such rejection and I will propose, finally, an alternative to the current university training of psychiatrists consistent with the principles of Szasz and critical psychiatrists.

I would like to reiterate that this thesis is a contribution to the growing wave of criticism of the excesses and falsehoods of biological psychiatry, experimental psychology and their social and clinical practice consequences. It is also an endorsement of those voices that, as Thomas Szasz did decades ago, call for a rigorous training in psychiatry and clinical psychology, an educated teaching, in continuous questioning and open to other fields of knowledge.

PART ONE

LIFE AND WORK OF THOMAS S. SZASZ

1. BIOGRAPHICAL NOTES

In order to make the figure of Thomas Szasz known, in this first chapter I will present the main milestones of his life grouped in three stages: a) from his birth until his appointment as university professor in 1956; b) from 1956 until 1962, paying special attention to the events known as "the Szasz case"; and c) from 1963 until his death in 2012. In the first stage I will mainly turn to his autobiography published in 2004 (Szasz, 2005a). For the rest of his biography, I will review the texts of other authors and the statements offered by Szasz in some interviews. Since there are not many writings on the biographical aspects of Szasz, I consider that the ones I use here are the most relevant for the intention of this paper. The aim of this exposition is not so much to recount Szasz's life in minute detail as to offer a profile of his person and to underline some significant facts that will serve both to justify my thesis that Szasz was a necessarily influential author in the later critical currents of psychiatry, and to understand the fact that many of them do not feel identified with him and, finally, to expose my own criticisms of this author.

1.1. FROM BUDAPEST TO SYRACUSE (1920-1956)

Thomas Stephen Szasz, or Szász Tamás István,[13]was born in Budapest (Hungary) on April 15, 1920. He was the second son, after György (later, George), two years older,[14]of a

[13]In Hungarian, the surname is placed before the given name.

[15]He had a happy childhood only disturbed by his delicate health. Soon after entering the *Gimnázium*,[16]Tamás felt the desire to study medicine, a vocation strongly opposed by his father (Gyula, an important agricultural merchant) since there was no medical tradition in the family and medicine was not a profitable business in Hungary at that time. But Tamás, perhaps because of his own health problems, was voraciously curious about the workings of the human organism. He was not interested in practicing medicine, but in knowing about medicine. His other early vocation was that of a writer (Szasz, 2005a, pp. 9-10).

When Hitler rose to power, Otto Szász, Tamás' paternal uncle, was dismissed from the University of Frankfurt, where he was a distinguished professor of mathematics, because of his Jewish (although he had previously converted to Catholicism) and foreign background. Soon Otto received invitations from several universities in North America, where he emigrated in 1933. After stays at *MIT* and *Brown University*, Otto eventually accepted a teaching position at the University of Cincinnati (*Op.cit.*, p. 10).

After the *Anschluss*[17], the Szászs decided to follow in Otto's footsteps and emigrate to the United States. But the U.S. immigration quota for Hungarians was full that year and there was no hope that it would be extended. Because of the long lists of applicants, the

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[14]Thomas Szasz always expressed admiration and gratitude to his brother George (Kerr, 1997, p. 39; Szasz, 2005a, pp. 6-7). His name appears in the "Acknowledgements" section of many of his books and he dedicated some of them to him, e.g., *The Ethics of Psychoanalysis* and *Pharmacracy*.

[15]His father's birth name was Schlesinger but, when he was a student, he "magyarized" it to Szasz to hide his Jewish ancestry (Kerr, 1997, p. 40).

[16]Equivalent to the Instituto de Educación Secundaria. Students entered at the of ten.

[17]Annexation of Austria to Nazi Germany in March 1938.

Szász would have to wait a long time for a visa. Finally, Gyula was able to find a way around the situation. The U.S. quota system by which visas were granted was not based on a person's current nationality but on the country of birth as it was called after 1920. The brothers Otto and Gyula Szász were born in the late 19th century northern Hungary, which was part of the Austro-Hungarian Empire. After the treaties of Versailles (1919) and Trianon (1920), which dismantled the empire after World War I, that area was incorporated into a new state: Czechoslovakia. Thus, Gyula could prove that he was born in Czechoslovakia, a nationality whose immigration quota was not complete in 1938. Finally, the Szászs could join Otto in the USA as legal immigrants (*Op.cit.*, pp. 10-11).

In July 1938, György was in Paris with the intention of leaving for England, and Tamás, who had just graduated from the *Gimnázium* and was fluent in French and German, was in Grenoble with the idea of entering medical school in the fall. Tamás received a letter from his father informing him that he and György were leaving for America and inviting him to make a decision. The three Szász boys met in Paris in August. Gyula left immediately for New York. György and Tamás had to wait for their father to make arrangements in the U.S. for the processing of their sons' visas and then send them to an embassy in Europe where the Szász brothers would pick them up. Fearing an imminent German invasion of France, György and Tamás fled to Rotterdam. In early October, visas arrived at the American consulate in Amsterdam, and finally György and Tamás embarked for the United States. After eleven days at sea, they arrived in Hoboken (New Jersey) on October 25, a date that is considered by Thomas Szasz as a second birth. His mother, Livia, arrived a few months later in

Cincinnati where his family lived, thus ending the Szász's life in Europe (*Op.cit.*, p. 11-13).

Despite his rudimentary English, Thomas enrolled at the University of Cincinnati in 1939 where he graduated with honors in physics in 1941. While studying, during 1940, he applied to twenty-six medical schools. By virtue of his brilliant academic record, almost all the faculties accepted his application, always conditional upon a personal interview. In many of these interviews Szasz was rejected because of his Jewish ancestry (Kerr, 1997, p.40). Finally, he was accepted to the medical school of the University of Cincinnati, where the good recommendations of his previous professors counted, in addition to being a resident of the city and nephew of Otto, a professor at the same university. Szasz began his medical studies in 1941 and graduated at the top of his class in 1944 (Szasz, 2005a, pp. 14-16).

Then, after a nine-month internship at *Harvard Medical Service* at *Boston City Hospital*, he began his medical residency in 1945 at his *alma mater*, *Cincinnati General Hospital*. Thomas was to a medical practitioner, something he had never desired. This prospect, in which practice prevailed over the true intellectual vocation, his passion for the humanities, caused Szasz to rethink his future (*Op. cit.*, p. 17). Thus, shortly after beginning his general medical residency in Cincinnati, Szasz decided to abandon his career as a practicing physician and begin a career as a psychotherapist. However, although he never considered himself a psychiatrist, he needed the title of physician.

psychiatrist to obtain authorization to work as a psychotherapist (Wyatt, 2004, p. 80)[18].

A voracious and restless reader from a very young age, Szasz studied the writings of Sigmund Freud and the Hungarian psychoanalyst Sándor Ferenczi in depth, so that he was better acquainted with the history of psychiatry and psychoanalysis than his psychiatry professors (Szasz, 2005a, p. 17). On the other hand, the satires on psychiatry and psychoanalysis by the Hungarian writer Karinthy Frigyes exerted a profound influence on the young Tamás, who even before leaving Hungary, had already come to the following conclusion:

> That psychiatry and psychoanalysis had nothing to do with real medicine [...]. Psychiatrists locked up troublesome persons in insane asylums for the benefit of their relatives; pychoanalysts, who were not supposed to touch their patients, engaged in a particular kind of conversation with them. Incarcerating people and talking to them were not medicine. [...] [But] in the United States psychoanalysis was defined a medical activity, a special kind of psychiatry (*Op.cit.*, pp. 17-18).[19].

He planned, therefore, to finish his general residency in 1946 and pursue a residency in psychiatry. In a conversation with the head of the department of medicine of the University

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[18]In the United States at that time only psychiatric physicians were authorized to practice psychotherapy since psychoanalysis was considered, contrary to Freud's postulation, a medical practice. [19] "That psychiatry and psychoanalysis had nothing to do with real medicine [...]. Psychiatrists locked up troublesome people in insane asylums for the benefit of their relatives; psychoanalysts, who were not supposed to touch their patients, engaged in a particular kind of conversation with them. Imprisoning people and talking to them was not medicine. [...] [But] in the United States psychoanalysis was defined as a medical activity, a special form of psychiatry."

Marion Blankenhorn of Cincinnati, in which Szasz told him of this decision, he said, "I'm sorry to hear that, Tom. Medicine is losing a good man" (*Op.cit.*, p.18). These words were remembered by Szasz whenever he heard psychiatrists claiming their identity as physicians. Just as Freud thought upon hearing Charcot say privately about the genesis of hysteria that "it is always about the genital, always," Szasz now wondered, "But if he thinks that, why does he express himself and act [in public] as if psychiatrists were real doctors?" (*Ibid.*).

Szasz chose to do his psychiatric residency at the hospital attached to the medical school of the University of Chicago. His reasons were that the university was oriented towards psychoanalysis and that the *Chicago Institute for Psychoanalysis*, a prestigious institution founded in 1932 by the Hungarian psychoanalyst Franz Alexander, was located in that city, where Szasz wanted to train. In 1946 he began his psychiatric residency and psychoanalytic training simultaneously. He was the only resident in the university's meager psychiatric department, which did not deal with serious cases but rather with everyday matters (marital or alcohol problems, depressive or anxious states, etc.) of upper-class people who came there because of the extremely discreet treatment (they were admitted to the hospital with a false and acceptable diagnosis, e.g. gastroenteritis). The head of the psychiatry department, Henry Brosin, warned Szasz that his training in that hospital would be incomplete for the later practice of psychiatry, as he would not gain experience with the seriously mentally ill there. He insisted, for his sake, that he complete his residency at *Cook County Hospital*, also located in Chicago. Szasz, as a young resident, did not see fit to express to his superior his ideas about mental illness and psychiatric coercion and his refusal to practice anything but private, consensual psychoanalysis. He communicated to his superior his desire to leave the

department of psychiatry at the University of Chicago and look for another place to finish his residency. The center chosen was *The Institute for Juvenile Research*, where he would see "families and their troubled children in the outpatient clinic" (*Op. cit*, pp. 19-21).

In 1948, while still a resident in psychiatry and a student at the institute of psychoanalysis, Szasz began seeing private patients as a private psychoanalyst. In 1950, after graduating from *the Chicago Institute for Psychoanalysis*, he joined the staff of training psychoanalysts. But Szasz was not comfortable with the way psychoanalysis was understood in the United States:

> It was obvious that my view of psychoanalysis, as an Enterprise separated from psychiatry - indeed, conceptually, economically, and morally antithetical to it- was not shared by my teachers or fellow trainees. The analysts passionately believed that they were treating real diseases, never voiced objections against psychiatric coecions, and believed that criminals were mentally ill and ought to be treated, not punished. These beliefs were an integral part of their self-perception as members of an avant-garde of scientific, liberal intellectuals. Psychoanalytic confidentiality was a myth, betrayed not only by training analysis and child analysis, but also by the loose lips of most of the analysts. [...] Many of the analysts hospitalized patients and gave then electric shock treatments. [...] All this was a far cry from my image of psychoanalysis based on the classics, the uncompromising European rejection of psychoanalysis as a medical activity, and my idealization of analytic confidentiality as
> sacrosant (*Op.cit.*, p. 23).[20].

[20] "It was obvious that my view of psychoanalysis, as a separate enterprise from psychiatry (conceptually, economically, morally and totally antithetical to it), was not shared by my trainers and colleagues. Analysts believed passionately that they treated genuine illnesses, never voiced objections to psychiatric coercion, and believed that criminals were mentally ill and should be treated, not punished. These beliefs were part and parcel of their self-perception as members of a

Szasz did not agree with the American institutional premise that only physicians could practice psychoanalysis (a premise, by the way, that Freud himself rejected in his 1926 article "Profane Analysis. Psychoanalysis and Medicine") nor with didactic psychoanalysis (compulsory psychoanalysis for trainees, directed by a psychoanalyst not chosen by the trainee but by the institution). These obligations that Szasz fulfilled in his training[21]he considered directly contrary to what he understood by "psychoanalysis". For this reason, being part of the psychoanalytic institution made him feel uncomfortable and he confessed: "once again I felt I had to escape" (*Op.cit.*, p. 24).

Already a qualified psychoanalyst, Szasz obtained his credentials as a psychiatrist in 1951. In the same year he married Rosine Loshkajian[22]and subsequently their daughter Margot was born.[23] Between 1947 and 1951, Szasz wrote eleven articles on the phenomena

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avant-garde of scientific-liberal intellectuals. Psychoanalytic confidentiality was a myth, betrayed not only in didactic psychoanalysis and child analysis but also by the loose tongues of most analysts. [...] Many analysts hospitalized their patients and administered electroshock treatments. [...] All this was light years away from my image of psychoanalysis based on the classic and forceful European rejection of psychoanalysis as a medical activity and from my idealization of analytic confidentiality as sacrosanct".

[21]Szasz conducted his didactic psychoanalysis with Therese Benedeck (Szasz, 2005a, p. 22).

[22]I am not aware that Szasz made any direct public reference to his wife or his relationship with her. The only clue I have found is in an interview in which Szasz says: "Personal circumstances can make a marriage unhappy, and the couple suffers in the marriage; their job is to get out of it. And it's not easy. I say that from experience" (Mitchell, 2009. This document is found on the Internet and the pages are not numbered. Hereafter, this applies to any reference where pages are not numbered). Szasz and his wife divorced in 1970 (http://www.szasz.com/Alumjournalarticle.pdf). Rosine died in 1971. In the eulogy

psychosomatics, a line of research of his mentor Franz Alexander. In 1952 he published an article with Alexander and wrote one of the chapters of one of his books. In the same year he signed one more article on psychosomatics and, for the first time, two articles on psychoanalytic theory. Between 1953 and 1954 he did not publish anything.[24]

After five years of intense private practice as a psychoanalyst in Chicago, in 1954 Szasz was called to join the US Army Reserve,[25]which was liberating news for him since, although he was grateful to earn a living as a psychoanalyst, he could not stand the long days of clinical work that left him little time for study and to be with his family. His destination, to which he went with his wife and daughter, was the *United States Naval Medical Center* in Bethesda (Maryland) where he stayed for two years and reached the rank of commander. There his second daughter, Suzy[(26)] ,was born in 1955 (Szasz, 2005a, p. 25). He became good friends with his colleagues and superiors, many of whom were psychoanalysts from Washington (most likely trained at the *Allanson White Institute*[(27)]),whom he considered more open-minded than the Chicago analysts.

which he wrote in 2012 after Szasz's death, Jeffrey Schaler reports: "Tom told me he was concerned about the effect

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his suicide would have on his daughters, considering that their mother, Rosine, also committed suicide after she and Tom divorced many years ago" (Schaler, 2012).

[23]Margot Szasz Peters is a dermatologist at *Mayo Medical School*, Rochester, Minnesota.

[24]See "Annex I" for complete references to Szasz's articles.

[25]In an interview, Szasz clarifies that: "I was exempted during World War II due to a heart murmur and thus went into the so-called 'medical reserve'" (Kerr, 1997, p. 41).

[26]Suzy Szasz Palmer is a librarian, dean of the *Greenwood Library* at *Long Wood University* in Farmville, Virginia.

[27]While *The Chicago Institute of Psychoanalysis* had an orthodox orientation, *The William Allanson White Institute* of Washington, directed by the renowned psychoanalyst Harry Stack Sullivan, had a renovating orientation of psychoanalysis. Its members were part of the culturalist, neo-Freudian school.

(*Op.cit.*, p. 25). Szasz's main job at Bethesda was to discharge service personnel due to "neuropsychiatric causes." "It was the only time I had involuntary patients," says Szasz (Kerr, 1997, p. 41).

In Bethesda, Szasz sees volunteer patients privately after hours and, in 1955, resumes writing articles. He wrote an article on the concept of entropy, two others on the phenomenon of pain, and most of his first book, *Pain and Pleasure* (Kerr 1997, p. 41). As early as 1956, in the months before he was discharged from the army and, probably, aware of his immediate future as a university professor (see *below*), Szasz writes, for the first time, three articles on the three subjects that will occupy his intellectual life from then on: psychotherapy ("On the Experiences of the Analyst in the Psychoanalytic Situation: A Contribution to the Theory of Psychoanalytic Treatment"); the relationship between psychiatry and the State ("Some Observations on the Relationship between Psychiatry and the Law"); and the philosophy of medicine and psychiatry ("A Contribution to the Philosophy of Medicine: The Basic Models of the Doctor Patient Relationship").

This last article he wrote with Marc Hollender, a good friend from the *Chicago Institute for Psychoanalysis* who was to play an important role in the period following the Bethesda stay. A friend of both, Julius Richmond, moved in 1953 from Chicago to Bethesda.

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or interpersonal psychoanalysis. This school developed in the USA in the 1940s as a reaction to the dogmatism of *ego psychology* (or orthodox psychoanalysis). Its representatives criticized Freud's metapsychological theories and renounced theorizing about the unconscious. Far from the abstractions of classical psychoanalysis and the rigidity of its practice, they advocated a psychoanalysis that was more direct, current and closer to the patient. They recognized, however, the importance of Freud's contributions to psychotherapy and to the understanding of the social aspects of the human being. In fact, the interpersonalists or culturalists never to consider themselves psychoanalysts.

to Syracuse (New York) to become head of the Department of Pediatrics at the *State University of New York* (SUNY) Medical School. In 1956, the chair of the Department of Psychiatry became vacant and, through Richmond's intercession, was offered to Hollender, who accepted. Shortly thereafter, Hollender offered Szasz a tenure-track position in Psychiatry (Szasz, 2005a, pp. 25-26).

On the choice of Syracuse as a residence, Szasz says that he left Chicago to free himself from the obligation to live solely from psychotherapy (Wyatt, 2004, p. 82). In this regard, in his autobiography he notes that:

> Having been drafted was a veritable *deus ex machina* to get me out of Chicago. [...] I had to have a plan for what to do when I was discharged. I did not want to resume my previous lifestyle if I could possibly help it. What I really wanted was an academic appointment in a university department of psychiatry, in a small town, where my duties would be mainly teaching, where I was not compelled by economic need to practice full time, and where I could have some time to think and write, in a free, academic environment. Again, I was lucky. A second deus ex machina suddenly offered me exactly the opportunity I was seeking (Szasz, 2005a, p. 26).[28]

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(28) "Being drafted was a real *deus ex machina* to run away from Chicago. [...] I had to have a plan for what to do when I got discharged. [...] If I could help it, I didn't want to resume my former lifestyle. What I really wanted was an appointment in a university department of psychiatry in a small town where my main task would be teaching, where I would not feel financially forced to work full time, and where I could have time to think and write in a free academic environment. Again, I was fortunate. Suddenly, a second *deus ex machina* offered me exactly the opportunity I was looking for."

In August 1956, Szasz moved with his family to Syracuse where, from then on, he developed his life and work as a full professor of psychiatry[29]until his retirement in 1990. Szasz concludes his autobiography here with this sentence: "for the rest of this story, I will let my work speak" (*Ibid.*).

Apart from these autobiographical notes and the interviews he gave, I have not found, in the texts he offered to the press, any other data on Szasz's personal life. It will be in his bibliography, in his *curriculum vitae*, in the chronicles that others wrote about him, in the dialectical exchanges with his adversaries and the interviews he gave where we will know Szasz better. Based on this, I follow the account where Szasz leaves him in his autobiography, just before taking up his post as a university professor.

1.2. THE FIRST YEARS AS A TEACHER. THE "SZASZ CASE" (1956- 1962)

Oliver (2006, p. 72) notes that Hollender hired Szasz in order to transfer the psychoanalytic curriculum of the *Chicago Institute for Psychoanalysis* to the university and to make its faculty a leading academic psychiatric residency. It should be noted here the socio-political context of psychiatry in which Szasz was trained and in which he began teaching, i.e., the post-war United States when, as Ron Leifer refers:

[29]In an interview he states that he never wanted to occupy a higher position because he never wanted to have power over others (Kerr, 1997, p. 43).

Psychoanalysis was in ascendance. It had been increasingly popular among American intellectuals during the 1930s. In the postwar intellectual ferment of the 1950s, it became the guiding theoretical framework of psychiatry. Its derivative, dynamic psychotherapy, was the most popular therapeutic modality. Therapists who did not have psychoanalytic training but who were psychoanalytically oriented practiced dynamic psychotherapy. Psychiatric faculties across the country were recruiting training analysts for chairmanships and professorships with the same enthusiasm, conviction, and exclusivity as they now recruit neurobiologists (Leifer, 2000).[30].

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[30]On the prevalence of psychoanalysis in early career in North America, Szasz notes that "it was during the postwar years (roughly 1946 through the 1970s) that the prestige of psychoanalysis in America and the influence of psychoanalysts on psychiatry reached its peak" (Szasz, 2005a, p. 20). Indeed, at that time, in the United States, there were two main options for those who wanted to engage in psychiatry and/or psychotherapy: on the one hand, biological or classical psychiatry which, lacking the current arsenal of psychoactive drugs, tried tremendously aggressive techniques such as lobotomy, electroshock or insulin or cardiazole shocks, and experimental behavioral psychology; and, on the other hand, psychoanalysis (as a synonym for psychotherapy in the absence of other currents that emerged after 1960 such as cognitive psychology and humanistic psychology), which was divided into two major currents or schools:

a) The orthodox, which considered itself the legitimate heir of Freud's legacy and which governed the *American Psychoanalytic Association* (the largest of the organizations that formed the *International Psychoanalytic Association* founded by Freud in 1910), represented by two major institutions: *The New York Psychoanalytic Society*, founded in 1911 by Abraham Brill, whose main representatives were Heinz Hartmann and Rudolph Loewenstein, promoters of the influential *psychology of the self*, and *The Chicago Institute for Psychoanalysis* founded by Franz Alexander in 1932, father of the so-called Chicago school centered, above all, on research into the relationship between medicine and psychoanalysis. Alexander, without departing from Freudian doctrine, contributed certain novelties such as brief psychoanalysis and the concept of "corrective emotional experience".

b) Interpersonal psychoanalysis, or neo-Freudian school, of Harry Stack Sullivan and Erich Fromm, founders, along with others, of *The William Alanson White Institute*, in 1946, with headquarters in Washington and New York. These authors raised criticisms of classical Freudian theory and practice. Basically, in theory they considered that the main determinants of human behavior were interpersonal relationships and not sexuality or innate instincts. In practice, they advocated a psychoanalysis based on a more egalitarian and participatory relationship between the psychoanalyst and the psychoanalyzer. Szasz's theories on psychotherapy agree, with nuances, with those of this current.

The neo-Freudians, influenced by the ideas of the first dissidents and critics of Freudianism (mainly Alfred Adler, Otto Rank and Sándor Ferenczi), proposed a renewal within psychoanalysis. In this line, they maintained links with the new English school of object relations theory. Between 1943 and 1944, the "Controversial Discussions" took place in England, organized by Sylvia Paine, president of *The British Society*. The differences between the followers of Anna Freud (orthodox) and those of Melanie Klein (renovators) were exposed and evidenced. One of the consequences of these discussions was the constitution, in 1951, of the *British Middle Group*, or independent group, formed by D. Winnicott, M. Balint,

W. Gillespie, J. Bowly, C. Rycroft and, later, R. Fairbairn, which gave rise to new theoretical approaches within and outside psychoanalysis.

For their part, the orthodox institutions in Chicago and New York, full of psychoanalysts who had fled Nazism, maintained, with certain theoretical adaptations, the Central European tradition represented by Anna Freud. Thus, in practice, the orthodox generally maintained the analytic device designed by Sigmund Freud (fundamentally, the systematic use of the couch, fixed time sessions, free association and the silence of the psychoanalyst), while the neo-Freudians proposed a more spontaneous device and a therapeutic relationship in which dialogue prevailed over the interpretation of the unconscious. On the other hand, while the orthodox advocated that psychoanalysis should and could only be practiced by physicians, the neo-Freudians advocated the extension of its practice to other non-medical but properly trained professionals, as Freud defended in his well-known 1926 article "Profane analysis (psychoanalysis and medicine)".

What definitely unites both trends is their "North Americanness", derived from the influence of pragmatic philosophy and represented by the ideal of the adaptation of the individual to the social environment, whereby, unlike classical European psychoanalysis, the *ego*, the conscious and the present become much more important.

Hollender's idea, notes Leifer (*Ibid.*), was to found a unique and avant-garde training center in Syracuse. He intended to bring the social sciences and humanities closer to the field of psychiatry in order to better understand psychological suffering. For this purpose, Hollender recruited for his department, in addition to Szasz, researchers from various disciplines such as, for example, the anthropologist Ernest Becker.[31]

From the security provided by his position as a full professor at the university, Szasz continued to write articles on the new lines of research mentioned above and published his first book, *Pain and Pleasure: a Study of Bodily Feelings* (Szasz, 1957),[32]in

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than the *id*, the unconscious and the past. Another characteristic of the North American psychoanalytic currents, unlike continental psychoanalysis, is the receptiveness, greater in the neo-Freudians than in the orthodox, to new ideas and contributions both in theory and in practice. It is not in vain that psychoanalysis in North America at that time owed its success and expansion to the inclusion in its institutions of psychoanalysts coming from and trained in very different places.

On the other hand, other important psychoanalysts such as Karl Menninger, founder, together with his father and his brother William, of the influential Menninger Clinic (Topeka, Kansas, 1919), defended a model of psychoanalysis integrating the previous approaches. In fact, Menninger maintained an active collaboration with representatives of both trends (Cf. Fine, 1979; Kaufmann (Ed.), 1996; Mitchell and Black, 2004; Schwartz, 1999; and Faulkner and Pruitt (Eds.), 1988).

[31]I regret not being able to deal in this thesis with the work of this magnificent author. Becker was a cultural anthropologist and, like Szasz, an outcast at the University for his heterodox views. Becker did not believe in specialization but in the combination of the social sciences for the better understanding of human life. His best known works are *The Birth and Death of Meaning* (1971), *The Denial of Death* (1973, Pulitzer Prize) and *Escape from Evil* (1974, posthumous).

[32]In the prologue to the Spanish edition of Szasz's book *The Second Sin*, Fernando Savater states that Szasz "studied medicine and psychiatry, obtaining his doctorate with a brilliant thesis on pain and pleasure" (Savater, 1985, p. 6). Szasz finished his medical studies in 1944 and wrote *Pain and* Pleasure thirteen years later.

which defends the thesis that the experiences of pleasure, pain and bodily sensations do not necessarily have an organic etiology. This work should be considered, because of its subject matter, different from the rest of the works that followed it. In it Szasz summarizes and puts an end to his research on psychosomatics. However, it already announces some of the ideas that he will develop extensively in his second book *The Myth of Mental Illness* (1961), such as the importance he gives to the symbolic use of language,

> It has been one of my purposes in this study to explore the problem of pain and pleasure from the point of view of symbolic meaning. I have been influenced by two different -and in many ways convergent- approaches. One is psychoanalysis, the other those branches of modern philosophy concerned with symbolism and semantics in particular and empiricism in general. [Susanne] Langer's *Philosophy in a New Key* is a representative example of this school of philosophy (Szasz, 1957, p. 11),[33]

or his commitment to an approach to psychiatric problems, specifically psychosomatic problems, not (or not exclusively) from the theoretical and methodological framework of the medical science to which the official psychiatry of the time claimed to belong, but from that of the social and human sciences:

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years later, in 1957. I am not aware that Szasz said that this book was his doctoral thesis or that it was inspired by it.

(33) "One of my intentions in this essay has been to explore the problem of pain and pleasure from the point of view of symbolic meaning. I have been influenced by two different perspectives although convergent in many respects. One is psychoanalysis, the other those branches of philosophy relating to symbolism and semantics in particular and empiricism in general. Susanne] Langer's *Philosophy in a New Key* is representative of this philosophical school."

> If instead of dwelling on the body as a physical machine we focus on a man and his relationships with himself and others, then the psychological method of observation and description is essential. [...] The relevance of the study presented in this book lies not only in its application to psychotherapy but its possible applications to sociology, ethics, and philosophy (*Op.cit.*, p. 243).[34]

In *Pain and Pleasure* Szasz also shows his intellectual leanings by declaring himself heir to some classics of psychoanalysis (Sigmund Freud, Otto Fenichel and Paul Schilder) and in tune with some contemporaries (Ronald Fairbairn and Ida Macalpine, representatives, respectively, of the British object relations and Kleinian schools, which were critical of psychoanalytic orthodoxy); and in field of philosophy of science he acknowledges the influence of the writings of Bertrand Russell, Susanne Langer, Hans Reichenbach, Gilbert Ryle and Alfred N. Whitehead (Op.cit., op. cit., p. 1). Whitehead (*Op.cit..*, p. x). These authors will be (with the exception of Schilder and Macalpine) major references in Szasz's subsequent works.

At the university, Szasz soon became very popular among the students and even some newspaper reporters attended his classes (Oliver, 2006, p. 72). His activism in defense of civil liberties and the personal responsibility of the so-called mentally ill culminated, in the early 1960s, in three events that brought him public notoriety.

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(34) "Instead of focusing on the body as a physical machine, we focus on the person and his relationships with himself and with others. In this sense, the psychological method of observation and description is essential. [...] The relevance of the study presented in this book lies not only in its application to psychotherapy but also in its possible applications to sociology, ethics and philosophy".

First, in May 1959 Szasz wrote a letter to Arthur Rosenthal, editor of Basic Books, who had published his first book in 1957. In that letter, Szasz told his publisher:

> I have put aside for the time being [...] my manuscript on the theory of psychoanalytic technique(35) [...]. Instead, I am now well on my way toward finishing a book on what is really an attempt to examine, in *extense*, the idea of "mental illness." [...] I think no really meaningful work on psychotherapy is possible until the nature of the alleged illness which is so being 'treated' is fully examined and clearly defined (Oliver, 2006, pp. 73-74).[36]

Three months later, Rosenthal received a manuscript entitled *Human Behavior and the Myth of Mental Illness: Foundations of a Theory of Psychiatry*, with an accompanying note from Szasz:

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[35]Szasz was probably referring to what would be his fifth book, published in 1965: *The Ethics of Psychoanalysis. The Theory and Method of Autonomous Psychotherapy.*

(36) "For the time being, I have put aside [...] my manuscript on the theory of psychoanalytic technique [...]. Instead, I am well on the way to finishing a book which is really an attempt to examine, at length, the idea of 'mental illness'. [...] I think that no meaningful work on psychotherapy is possible until the nature of the supposed illness that is being 'treated' is fully examined and clearly defined".

> Let us suppose that there is no such thing as mental health or mental illness, [...] that these words refer to nothing more substantial or real than did the astrological notions of the influence of planetary positions on personal conduct. What then? (*Op.cit.*, p. 74).[37]

It was not Rosenthal but another publisher, Paul B. Hoeber, who finally published in 1961 Szasz's second work, *The Myth of Mental Illness*, with which he became world famous and which, as I will indicate, caused him serious problems with the psychiatric establishment of the time, but for which he also received praise from prestigious authors such as Karl Popper.[38]

Second, that same year in 1961 Szasz appeared before the Senate subcommittee on the constitutional rights of the mentally ill, where he argued strongly that such rights were systematically violated by psychiatrists in both courts of law and psychiatric hospitals. Szasz told the senators:

> The crucial issue in all of these situations is whether the psychiatrist is to be considered the agent of the patient or of someone else [...]. We must constantly ask ourselves questions such as these. [Is he a therapist or a custodian? Is he a "doctor," or is he a "warden" of an

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(37) "Suppose there were no such things as mental health or mental illness, that these words did not refer to anything more substantial or real than did astrological notions of planetary influence on personal behavior. What then?"

[38]I quote the first words of a letter Popper sent to Szasz on July 20, 1961:

"My dear Doctor Szasz, thank you very much for sending me your truly admirable book, The *Myth of Mental Illness*. Although my eyesight makes reading difficult, I found it so fascinating that I read it at one go. It is a most important book, and it marks a real revolution. Besides, it is written in that only too rare spirit of a man who wants to be understood rather than to impress" (http://www.szasz.com/popper.html).

institution which, although it is called "hospital," functions as a prison, inasmuch as patients cannot leave it at will? (*Ibid.*, p. 74).[39].

Finally, on April 12 and 13, 1962, Szasz intervened in a *habeas corpus* proceeding where he attacked a court decision based on psychiatric reports. In 1955, Michael L. Chomentowski[40]decided to sell his gas station to a real estate agent. When, without having yet signed the agreement, the latter's workers came to occupy the gas station, Chomentowski threatened them by firing his gun into the air. He was immediately arrested and underwent a psychiatric examination (Schaler, 2005, p. xviii). After conducting a dubious evaluation,[41] the forensic psychiatrists considered that Michael

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[39] "The crucial question in all these situations is whether the psychiatrist considers himself to be the agent of the patient or of others [...]. We must constantly ask ourselves questions such as these: [...] Is the therapist a guardian? Is he a 'doctor' or is he the 'warden' of an institution which, although it is called a 'hospital', functions as a prison since patients cannot leave it at will?"

[40]Schaler (2005) and Leifer (2000) refer to Chomentowski as "John". However, both Oliver (2006) and the newspapers that most extensively covered this case between 1955 and 1967 (*The Syracuse Herald Journal*, *The Post-Standard* and *The Assabet Valley Beacon*) refer to him as "Michael," a name I take as valid. For his part, Szasz recounts this case in detail in Chapter 4 of his book *Psychiatric Justice* (1965), hiding Michael Chomentowski's name under "Louis Perroni." Chomentowski was released in 1967 after the U.S. Supreme Court found some aspects of involuntary commitment unconstitutional.

[41] "The doctors were 'convinced' of the 'possibility' that Chomentowski was 'potentially' dangerous. Moreover, Chomentowski's 1957 diagnosis, along with a subsequent diagnosis in 1962, was identical to that of 1955, even though the latter two were based on symptoms that were not only different but precisely opposite. In 1955, Chomentowski was 'grandiose,' 'mildly euphoric,' 'over-productive and spontaneous.' In 1962, 'His stream lacked spontaneity; he was negativistic with delayed reaction time and psychomotor retardation and his affect was blunted.' In both cases, it was 'undoubtedly' a schizophrenic reaction" (Oliver, 2006, p. 77).

Chomentowski was unfit to stand trial due to an alleged mental illness, and the judge ordered him committed to a psychiatric hospital even though he had not been convicted of any crime. By the time Szasz intervened in the case (1962), Chomentowski had already been confined for seven years (since 1955), about five years longer than the prison sentence he would have received had he been convicted of his crime (Oliver, 2006, p. 74).

Szasz was against both the judicial confinement (*civil commitment*) of the so-called mentally ill and the application of exonerating or mitigating circumstances to sentences through the allegation that the defendant suffers from a mental illness (*insanity defense*). He always defended that freedom (according to him, the ultimate good of the human being), was based on personal responsibility. If an adult individual is granted not to be responsible for his actions and, therefore, is exempted from the consequences, it is impossible for him to be free. In this regard, Szasz testified before the judge, contrary to what was pointed out by the psychiatrists in charge of the case, that Chomentowski was (should have been) perfectly capable of understanding the accusations and, therefore, capable of attending his trial under normal conditions. Moreover, in response to questions from the judge and the lawyers and prosecutors, Szasz stated in non-technical language that mental illnesses were nothing but inventions of psychiatrists and that insane asylums were prisons (Leifer, 2000). The judge asked Szasz: "Doctor, you speak of the 'myth' of mental illness. In layman's terms, would that mean that mental illness does not exist?" (Oliver 2006, p. 78), to which Szasz responded:

> You seem to think that a myth refers to something that doesn't exist. [...] A myth is not a word properly used that refers to something that doesn't exist. It refers to a kind of collective reasoning that people make; that odd things which are variably upsetting to people-odd things that people do, such as killing their mothers or mothers throwing their children out of a

seventh-story window, all sorts of terrible things -these things that exist, they very much exist. I am trying to do as much about these things as anybody else. I think a little bit more. The issue is what are these things? The myth refers to the fact that the people say they are illnesses that doctors can cure. I say they are wrong. They are not illnesses people can cure. They are using the term mental illness mistakenly. [...] People who drink and beat up their wife-I don't like them any more than you do-but I don't think they are insane. I think they are badly mistaken, ignorant, stupid, misled, upset- but they are not sick like with pneumonia. If that isn't clear I will be glad to answer it further (*Op.cit.*, pp. 78-79).[42]

In this sense, Szasz raises the question of "myth" in the manner of Gilbert Ryle (*The Concept of the Mental*), in reference to a categorical error: "Ryle defined a myth not as a fairy tale but as the presentation of the facts of one logical category [e.g. moral choices] in the language appropriate to another [e.g. organic diseases]" (Leifer, 2000).

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(42) "Perhaps you consider that a myth refers to something that does not exist. [Myth is not an adequate word to refer to something that does not exist. It refers to a kind of collective reasoning that people build up about strange vicissitudes that upset people (strange things that people do, like killing their mothers, or mothers throwing their children out of a seventh-story window, all sorts of terrible events). These circumstances exist, of course they exist. I try to fight them like nobody else. But I think a little bit more. The question is, what are these things? The myth has to do with the fact that people say they are diseases that doctors can cure. I say that is false. They are not diseases that anyone can cure. The term mental illness is being used wrongly. [...] I don't appreciate those who drink and beat their wives any more than you do but I don't think they are insane. I think they are terribly wrong, that they are ignorant, stupid, deviant, that they are angry, but not that they are sick as if they were sick with pneumonia. If this is not clear, I will be happy to respond further."

After the publication of *The Myth of Mental Illness* and the two public appearances mentioned above, the press echoed Szasz's views not only against psychiatric methods but also against the cornerstone of psychiatry: the concept of mental illness. His fame grew like wildfire inside and outside the psychiatric profession. Szasz was beginning to pose a serious threat to the psychiatric establishment, which henceforth considered him a dangerous heretic who had to be silenced. It was then that the events known as the "Szasz case" (Schaler, 2005, pp. XVIII-XXI and 393-402) unfolded, which I refer to below.

Abraham Halpern, mental health commissioner for Onondaga County and associate professor of psychiatry at SUNY-Syracuse, was present in the courtroom when Szasz testified in the Chomentowski case. Halpern was seated near the prosecution bench advising the district attorney, passing notes to him and suggesting questions (Oliver, 2006, pp. 77-78). As a member of the administration, he was very upset and, as a psychiatrist, attacked by Szasz's statements.[43]His complaints, along with those of other psychiatrists, reached the ears of Paul Hoch, state commissioner of mental hygiene, and Newton Bigelow, director of *Marcy State Hospital*[44]and editor of the prestigious journal *The Psychiatric Quarterly*. Bigelow published in it a harsh article against Szasz in which he criticized his testimony in the Chomentowski case: "What follows here is [...] a factual report on a dogmatic position that has sought to present a damaging image of the state hospital and an even more distorted one of the psychiatrists who work there" (Bigelow, 1962, p. 755). For his part, Hoch wanted to expel Szasz from the Syracuse psychiatric hospital he was associated with.

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(43) "Halpern, now [2006] an octogenarian, considers himself a close friend of Szasz and is ashamed of the he conducted himself in denouncing him" (Oliver, p. 78).

[44]*Marcy State Hospital* was a well-known insane asylum (formerly a tuberculosis sanatorium founded in 1915) located in Pittsburgh, Pennsylvania. It was closed in 1982.

to the department of psychiatry at the medical school and where residents were trained. On November 21, 1962, Hoch wrote a letter to the head of the department and, at the time, director of the psychiatric hospital, Marc Hollender, Szasz's old friend, ordering him to expel him:

> Dear Dr. Hollender:
>
> At our recent meeting in Albany, we discussed the situation relating to Dr. Thomas Szasz. I told you that Dr. Szasz is entitled to his opinion but that I cannot agree that he should teach in the framework of the Department of Mental Hygiene and instruct our residents that, as I understand him, that mental diseases do not exist and therefore installations for the treatment of mental disorders are a detriment to their welfare.
>
> I have no authority about Dr. Szass' [sic] teachings in the medical school, but I direct you to terminate Dr. Szass' to the residents of the state institutions and to any personnel which is employed by the Department of Mental Hygiene of the State of New York (Schaler, 2005, pp. 393-394).

Five days later, on November 26, 1962, Hollender sent the following note to.

Szasz:

> As Director of the Syracuse Psychiatric Hospital, I have been directed by the Commissioner of the Department of Mental Hygiene of the State of New York to inform you that you can no longer conduct your seminar for residents of the Upstate Medical Center at the Syracuse Psychiatric Hospital. As Chairman of the Department of Psychiatry at the Upstate Medical Center, I have asked Dr. Robinson to arrange for another room in which you can conduct your seminar (*Op.cit.*, p. 394).

"It was as if Marc was telling me, 'You have to wear a yellow star,'" says Szasz (Oliver 2006, p. 80). Eventually, some colleagues and students protested the expulsion by boycotting classes and staff meetings. Local newspapers published impassioned comments: "'One of the most flagrant violations of academic freedom in the history of the faculty' [...] 'Szasz is the victim of a virtual academic crucifixion'" (*Ibid.*).

To the ostracism ordered by Hollender, Szasz responded that if he was not allowed to teach at the hospital he would not attend any psychiatry department meetings there either (Hollender, who held senior positions in both places, had moved his office from the faculty to the hospital) (Leifer, 2000). In response to this insubordination, Hollender increased Szasz's teaching load and supervision of his work and reduced his secretarial staff (Schaler, 2005, p. xix). In protest against the censorship imposed on their colleague, some professors also made the decision to leave the hospital.

In March 1963, a group of thirty psychiatric residents at Syracuse Psychiatric Hospital informed Szasz that they had sent letters of protest to Paul Hoch, Robert King (chairman of Committee A of the AAUP[45]), and Nelson Rokefeller, governor of New York State. The three letters were very similar, see below for an excerpt from the one to Hoch:

> Dear Dr. Hoch:
>
> [...] Dr. Szasz is not hurt by your attempts to restrict him as much as we residents are, because Dr. Szasz' "political" views in psychiatry are in no way a reflection of his

[45] *American Association of University Professors.*

> competence to teach a course in psychotherapy which is considered by us to be the highlight course of the residency program.
>
> [...] As psysicians, we resent the implication, even if unintentional, that we may somehow be influenced or tainted by Szaszian heresy. We are quite able to evaluate, accept, or reject ideas, even when expounded by the most convincing and influential personalities.
>
> If Dr. Szasz' techniques of criticism result in personal affronts and hurts, then such matters should be handled by the individuals involved, rather than by quasi-political maneuvers involving others. It is our sincere hope that the directive against Professor Szasz will be rescinded, for it is freedom of expression without fear of reprisal that is the real issue, not Dr. Szasz' views. Without freedom of expression, psychiatry can lay no claim to science. We are not so much afraid for Dr. Szasz, we are afraid for psychiatry (*Op.cit.*, pp. 393-394).

However, other faculty and residents were highly critical of Szasz's ideas and positions and advocated for his expulsion not only from the hospital but from the faculty itself (Leifer, 2000). Faced with such a threat, Szasz appealed, through his young lawyer George Alexander, to the medical school administrators and the AAUP, who investigated the conflict and felt that Hollender's actions violated Szasz's academic freedom (Schaler, 2005, p. xx). Even if he was prohibited from teaching at the hospital, Szasz could not be dismissed from the faculty. In retaliation, Hollender immediately fired Ernest Becker, Szasz's close collaborator (Leifer, 2000). Ron Leifer, who formed with Szasz and Becker the core of the dissent, was likewise fired a few years later (*Ibid.*).

Al Higgins, a sociologist who at the time worked with Szasz at the university, states: "The reaction of the medical profession, the reaction of his psychiatrist colleagues is an incredible example of the ways in which a profession controls its members".

(Oliver, 2006, p. 79). For his part, Ron Leifer, a psychiatry resident under Szasz's tutelage and later an associate professor on the same faculty in those years, says: "I think this is a story that needs to be told and reflected upon. It illustrates how and why intellectual thought is subtly controlled by academic power brokers and, in this case, how the repression of Thomas Szasz and his students reflects the ironic predicament in which modern psychiatry finds itself" (Leifer, 2000). Leifer laments the frustration of Szasz's academic project, a project that, as I will show in later chapters, is today defended by critical psychiatrists:

> We can only speculate what course psychiatric history might have taken had Szasz not been repressed and had Becker and I not been fired from the medical school at Syracuse. [...] Possibly, a school of thought might have developed at Syracuse which would provide a critical alternative to the current ideological hegemony of contemporary medical-coercive psychiatry (*Ibid.*).

1.3. A LIFE COMMITTED TO THE CAUSE OF FREEDOM (1963-2012)

Thereafter, Szasz continued to teach at the university. About the subjects he taught students he notes:

> I taught them conventional psychiatry. Kraepelin and Bleuler and Meyer, things medical students ought to know. [...] My position, I feel, was similar to that of a Professor of Religion

who [...] doesn't have to believe in the truths of any of these creeds, but he ought to know what they are (Kerr, 1997, p. 43).[46].

He also continued his intense activity as an essayist. He published hundreds of articles in the most prestigious scientific, medical, psychiatric, psychological, psychoanalytic and legal journals, as well as in newspapers and generalist magazines.[47]He wrote a total of 35 books, 26 of them originals on psychotherapy, philosophy of psychiatry, criticism of psychiatric practices and social issues such as drugs and suicide, and nine others of aphorisms and compilations of articles.[48]

He was invited as a guest lecturer in institutions in many countries, including Spain on two occasions.[49]Among his many merits, he was named Doctor *honoris causa.*

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(46) "I taught them conventional psychiatry. Kraepelin, Bleuler and Meyer, authors whom medical students should know. [...] I consider that my position was similar to that a professor of religion [...] who does not have to believe in the truths of any creed but should know them".

[47]For example, *Science*, *Nature*, *The Lancet*, *Archives of Internal Medicine*, *Archives of Neurology and Psychiatry*, *Journal of Nervous and Mental Disease*, *Archives of General Psychiatry*, *American Journal of Psychiatry*, *British Journal of Psychiatry*, *History of Psychiatry*, *American Psychologist*, *American Journal of Psychotherapy*, *International Journal of Psychoanalysis*, *Columbia Law Review*, *Criminal Law Bulletin*, *Yale Review*, *The New York Times*, *The Washington Post*, *The Humanist*, *Current*, *Inquiry*, *Harper's Magazine*, etc. [48]See Appendix II.

[49]The first was in 1987, invited to the seminar held in Cuenca by the *Menéndez Pelayo International University* entitled *Chemistry and Ritual*, where he met, among others, Albert Hoffman, creator of LSD. Szasz's lecture was entitled "The morality of drug control". Fernando Savater wrote an article on the subject: "Drugs without panic". *(El País*, May 22, 1987, http://elpais.com/diario/1987/05/22/sociedad/548632803_850215.html).

by the following universities: Allegheny College (Pennsylvania) (1975), Francisco Marroquin (Guatemala) (1979), Towson (Maryland) (1999) and Upstate Medical (S.U.N.Y.) (New York) (2001). He was a life member of the *American Psychiatric Association*, the *American Psychoanalytic Association* and the *International Psychoanalytic Association*, among many other associations. *The Center for Independent Thought* (located in New York and San Francisco) established, in 1990, *The Thomas S. Szasz Award for Contributions to the Cause of Civil Liberties* which is given annually.

If Szasz is known for anything, it is for his struggle against psychiatric power and in favor of individual liberties. In 1970 he founded, together with sociologist Erving Goffman and jurist George Alexander, *The American Association for the Abolition of Involuntary Mental Hospitalization* (AAAIMH), which remained active until 1979. The association periodically published a newsletter called *The Abolitionist*.[50]In 1969 he founded, together with the Church of Scientology, *The Citizen Commission on Human Rights* (CCHR).[51]This one-off association between Szasz and Scientology eventually raised some criticism to which Jeffrey Schaler, owner and editor of the website www.szasz.com, responded by publishing the following note authorized by Szasz himself in which he disassociated him from all ties (with the exception of this association) with the Church of Scientology:

Szasz's second visit was in 1993, as director of another seminar at the same university, this time in La Coruña, entitled *Una mirada crítica a la psiquiatría (A critical look at psychiatry)*. This visit was referred to by Manuel Rivas in his article "El sabio iconoclasta" (The iconoclastic sage).

(*El País*, July 25, 1993 (http://elpais.com/diario/1993/07/25/sociedad/743551208_850215.html).

[50]See the AAAIMH's articles of incorporation and dissolution document at www.szasz.com.

[51]Today, this association is still very active, mainly against the mass prescription of psychotropic drugs and the medicalization of daily life.

> The following statement is intended as response to requests for clarification regarding Dr. Szasz's co-founding of the Citizens Commission for Human Rights (CCHR). Thomas Szasz is not now nor has he ever been a Scientologist or a member of the Church of Scientology.
>
> Dr. Szasz co-founded CCHR in the same spirit as he had co-founded - with sociologist Erving Goffman and law professor George Alexander - The American Association for the Abolition for Involuntary Mental Hospitalization (AAAIMH). Scientologists have joined Szasz's battle against institutional psychiatry. Dr. Szasz welcomes the support of Jews, Christians, Muslims, and any other religious or atheist group committed to the struggle against the Therapeutic State. Sharing this battle does not mean that Dr. Szasz supports the unrelated principles and causes of any religious or non-religious organization. This is explicit and implicit in Dr. Szasz's work. Everyone and anyone is welcome to join in the struggle for individual liberty and personal responsibility - especially as these values are threatened by psychiatric ideas and interventions (Schaler, 2003).

In a subsequent interview, Szasz comments:

> I got affiliated with an organisation long after I was established as a critic of psychiatry, called Citizens Commission for Human Rights, because they were then the only organisation and they still are the only organisation who had money and had some access to lawyers and were active in trying to free mental patients who were incarcerated in mental hospitals with whom there was nothing wrong, who had committed no crimes, who wanted to get out of the hospital. And that to me was a very worthwhile cause; it's still a very worthwhile cause. I no more believe in their religion or their beliefs than I believe in the beliefs of any other religion. I am an atheist, I don't believe in Christianity, in Judaism, in Islam, in Buddhism and I don't believe in Scientology. I have nothing to do with Scientology (Mitchell 2009).[52].

[52]Long after I had established myself as a critic of psychiatry, I became associated with an organization called the *Citizen Commission for Human Rights* because, at the , it was (and still) the only organization

Finally, he led the prosecution with George Alexander at the fifth *Russell Tribunal* (Berlin, 2001), dedicated to human rights in psychiatry.[53]As noted above, Szasz retired in 1990 at the age of seventy and 34 years as a professor of psychiatry at the same university where he started. He passed away on September 8, 2012. Within days, *The New York Times*, among many other newspapers, published an obituary reporting that he "died after a fall" (Carey, 2012). This is the version that transcended to the media. However, the aforementioned eulogy that Jeffrey Schaler dedicated to Szasz begins thus:

> It saddens me to write that Thomas Stephen Szasz died by his own hand on September 8, 2012, at his home in Manlius, New York, after a fall that occurred less than a week earlier. When he fell at home, he broke T-10, the tenth thoracic vertebrae in his spine, confirmed by a physician at a local hospital using x-ray. The hospital physician wanted to admit him and put him on what would likely have been a morphine drip, and proposed surgery to help heal the break -there was talk about inserting a piece of plastic to hold the vertebral fracture together so it could heal, but Tom would have none of that. I am not surprised. He requested a prescription for pain medicine, and was taken to a pharmacy and then home by one of his closest friends. He was found dead a few days later when two other friends went to check on

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who had funds, some access to lawyers, and who was engaged in trying to free mental patients incarcerated in psychiatric hospitals, who had done nothing wrong, who had committed no crimes, who wanted to get out of the hospital. To me it was, and still is, a very worthwhile cause. I don't believe in their religion or their beliefs any more than I believe in the beliefs of any other religion. I am an atheist, I don't believe in Christianity, I don't believe in Judaism, I don't believe Islam, I don't believe in Buddhism, and I don't believe in Scientology. I have nothing to do with Scientology.

[53]The first Russell Tribunal, whose presidents were B. Russell and J. P. Sartre, was held in Stockholm and Copenhagen in 1967 and was devoted to international war crimes in Vietnam. The latest, on war crimes in Ukraine, was held in Venice in 2014.

> him. It is not known whether the prescription for pain pills is what he used to end his life. Apparently, he swallowed all of those pills, however, he always told me that he had a reserve supply of Seconal and other pills that he would use when he needed to take his death into his own hands (Schaler, 2012).

If so, it must be recognized that Thomas S. Szasz died in a manner consistent with his strong liberal principles. These, along with the rest of his system of thought, will be set out in greater detail in the chapter that follows in order to complete the personal and professional portrait of this author whom I consider fundamental in the history of critical psychiatry.

2. SYSTEM OF THOUGHT[54]

In his first ten years as a university professor (1956-1965), Szasz counts about a hundred bibliographical references.[55]It is in this decade that Szasz establishes the system of thought that he maintained without variation throughout his life. In order to demonstrate this assertion, in this section I will quote alternatively extracts from: a) several articles and three of the four books Szasz published in the beginning of his academic career: *The Myth of Mental Illness* (1961b); *Law, Liberty, and Psychiatry* (1968); and *The Ethics of Psychoanalysis* (1965a);[(56) b]) statements Szasz made in eight of the many interviews he gave covering 40 years of his life (from 1969 to 2009); and c) six of the books he wrote in his last 25 years of production (1987-2012): *Insanity: The Idea and Its Consequences* (1987); *A Lexicon of Lunacy: Metaphoric Malady, Responsibility, and Psychiatry* (1993); *The Meaning of Mind: Language, Morality, and Neuroscience* (1996); *Pharmacracy: Medicine and Politics in America* (2001); *Coercion as Cure: A Critical History of Psychiatry* (2007); and *Psychiatry: The Science of Lies* (2008a). Although, as I state, the basic premises that Szasz holds in these last books are the same as those he has held since 1956, the interest of these last works lies in the fact that Szasz questions the new positivist psychiatric context that emerged in the 1980s (and is still valid today) with the rise of neuroscientific research that seemed to confirm the organic origin of mental disorders, of the medically oriented diagnostic classifications (*DSM*), and of the new psychiatric theory of psychiatry, which is still in force today.

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[54]Compare this chapter, which derives from my personal reading of Szasz's work, with the 1983 book edited by Richard Vatz and Lee S. Weinberg, *Thomas Szasz: Primary Values and Major Contentions*.

[55]See Annex I.

[56]As already noted, Szasz's first book, *Pain and Pleasure* (1957e), dealt with the experience of pain and was based on his early articles psychosomatic phenomena, aspects he hardly dealt with again after the publication of this work and which are not the subject of this thesis.

based on the presence of symptoms, of the indiscriminate use of psychopharmacology as the main method to "cure" "mental illnesses", etc. This positivist program has come to become an unquestioned truth preached in universities and applied in psychiatric practice, in schools and in courts of law, animated by the ethics of beneficence contrary to the ethics of autonomy and responsibility which, as I will show below, Szasz advocates: "The *DSM*, psychopharmacology, involuntary outpatient treatment and the 'duty to protect' have set the beneficent standard of psychiatry. Departure from it is penalized by a tort suit and loss of professional license" (Szasz, 2007, p. 223).

As I will indicate in this chapter, Szasz had two main objectives: a) to demonstrate the logical and conceptual error of the term "mental illness" and to denounce the consequences that derive from it; and b) to abolish institutional psychiatry which, under the pretext of doing a charitable act, exercises coercion on people such as involuntary psychiatric hospitalization (*civil commitment*) of innocent people and justifications such as the legal defense for insanity (*insanity defense*) from which guilty people benefit. The first mission falls within the field of the philosophy of psychiatry and second belongs to the more general field of the "critique of psychiatry", i.e. the political critique of the social function of psychiatry and its methods. In Szasz there is not one without the other: he will use conceptual and epistemological analysis as a basis for launching his criticisms of psychiatry, with both strands being inscribed in a markedly liberal ideology:

> My critique of psychiatry is two pronged. One of my criticisms is conceptual: that is, that mental illness is not a real illness. The other one is political: that is, that mental illness is a piece of justificatory rhetoric, legitimizing civil commitment and the insanity defense. Dermatologists, ophthalmologists, gynecologists, don't have any patients who don't want to

be their patients. But the psychiatrists' patients are paradigmatically involuntary. Originally, all mental patients were involuntary. [...] In my view, involuntary hospitalization and the insanity defense ought to be abolished, exactly as slavery was abolished, or the disfranchisement of women was abolished, or the persecution of homosexuals was abolished. Only then could we begin to examine so-called mental illnesses as forms of behavior, like other behaviors (Wyatt, 2004, p. 75).[57]

As can be seen in the preceding quote, Szasz was concerned with unveiling the deceptions to which certain handling of language leads us with respect to the concept of "mental illness" and, at the same time, he was a standard bearer of liberalism[58]in his struggle against the coercive practices of

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(57) "My criticism of psychiatry is twofold. One of my criticisms is conceptual, that is, that mental illness not a real illness. The other is political, that is, that mental illness is part of the justifying rhetoric that legitimizes civil confinement and the insanity defense. Dermatologists, ophthalmologists, gynecologists, do not have patients who do not wish to be their patients. But psychiatrists' patients are paradigmatically involuntary. [In my opinion, involuntary hospitalization and the insanity defense should be abolished, just as slavery, the disenfranchisement of women and persecution of homosexuals were abolished. Only then could we begin to examine so-called mental illness as forms of behavior, like any other behavior."

[58]Szasz defined himself as a *libertarian* and an advocate of *libertarianism*. However, in Spanish, "libertarianism" resonates with "anarchism" or "libertarian communism", ideologies that Szasz rejected. He was a liberal in the sense of classical Anglo-Saxon liberalism as were, for example, John Stuart Mill or Thomas Jefferson. Szasz's intellectual preferences can be seen in the following interview:

"Who are the your heroes, since childhood and now? Szasz: Where should I start? There are many: Shakespeare, Goethe, Adam Smith, Jefferson, Madison, John Stuart Mill, Mark Twain, Mencken, Tolstoy, Dostoyevski, Chekhov. Orwell, C. S. Lewis. Ludwig von Mises, F. A. Hayek. Camus, and Sartre, though personally and politically, Sartre is rather despicable. He was a communist sympathizer. [...] Camus was a much better person, a much more admirable human being. He was also a terrific writer. "Who are his heroes, in childhood and in

the present time? Szasz: Where should I start? There are many: Shakespeare, Goethe, Adam Smith, Jefferson, Madison, John Stuart Mill, Mark Twain, Menken, Tolstoy, Dostoevsky, Chekhov. Orwell, C. S. Lewis. Ludwig von Mises, F. A. Hayek. Camus and Sartre, even though Sartre is, personally and politically, rather despicable. He was a communist sympathizer. [Camus was a better person, a much more admirable human being. He was also a magnificent writer" (Wyatt, 2004, pp. 84-85).

In view of the above and in order to avoid confusion, in this thesis I will translate *"libertarian"* and "*libertarian"* as *"libertarian"*.

"libertarianism" for "liberal" and "liberalism". For example:

"I am a libertarian. [...] Now, in term of political philosophy, libertarianism is what, in the 19th century, was called liberalism. Nowadays it's sometimes also called 'classical liberalism.' It's a political ideology that views the state as an apparatus with a monopoly on the legitimate use of force and hence a danger to individual liberty. Contrariwise, the modern 'liberal' view regards the state as a protector, a benevolent parent who provides security for its citizens as quasi-children. To me, being a libertarian means regarding people as adults, responsible for their behavior; expecting them to support themselves, instead of being supported by the government; expecting them to pay for what they want, instead of getting it from doctors or the state because they need it; it's the old Jeffersonian idea that he who governs least, governs best. The law should protect people in their rights to life, liberty, and property from other people who want to deprive them of these goods. The law should not protect people from themselves" (Wyatt, 2004, pp. 78-79).

"I am a *libertarian*. [*Libertarianism*, in terms of political philosophy, is what was called *liberalism* in the 19th . Today it is also sometimes referred to as 'classical liberalism'. It is a political ideology that regards the state as a system that monopolizes the legitimate use of force and, therefore, as a danger to individual freedom. By contrast, the modern 'liberal' perspective views the state as a protective and benevolent parent that provides security to its citizens as if they were quasi-children. To me, being a liberal means regarding people as adults, responsible for their behavior; expecting them to provide for themselves, rather than being provided for by the government; expecting them to pay for what they want, rather than receiving from doctors or the state what they 'need'. It is the old Jeffersonian idea that he who governs least governs best. The law should protect people in their right to life, liberty and property from others who wish to deprive them of these goods. The law should not protect people from themselves" (Wyatt, 2004, pp. 78-79).

institutional psychiatry. Thus, language and freedom are the two pillars on which Szasz bases the mission to which he dedicated his life and work: "My objections to psychiatry are twofold: one has to do with freedom, the other with language. Freedom and language are two of the most important things in life" (Szasz, 1974a, p. 7).

In the following quotations it can be observed, once again, the link that Szasz establishes between the analysis of the foundations of psychiatric knowledge and the critique of coercive psychiatry:

> A disease is some kind of abnormality of the human body and that the mind is obviously semantically, linguistically, it is not a part of the human body. So there was the first question about mental illness. The second one was [...] that mental patients [...] are prisoners, they are not patients, they can get into the hospital but they can't get out. [...] So I put two and two together and concluded that this is a social phenomenon which has nothing to do with medicine (Mitchell, 2009).[59]

> Psychiatry's mandate to protect people from themselves -masturbation in the old days, drugs and suicide today- is at the core of what I consider to be its intrinsically unscientific and morally problematic (to put it mildly) character. We are now mired in the results of this medicalisation of moral and social "problems", which we conceptualise as mental diseases.

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(59) "A disease is a certain type of abnormality of the human body. Obviously, the mind is something semantic, linguistic, it is not a part of the human body. This was the first question about mental illness. The second was [...] that mental patients [...] are prisoners, not patients, they can enter the hospital but they cannot leave it. [...] So, I put these two questions together and concluded that this social phenomenon has nothing to do with medicine."

and try to remedy by drugs and coercions we call "psychiatric treatments" Kerr, 1997, p. 44).[60].

In addition to being a philosopher and political critic of psychiatry, Szasz was a theorist of human behavior and psychotherapy. He put forward a new way of understanding not only the so-called "mental illness" but human behavior in general, not from a medical but from a semiotic and social perspective. He defends, as an alternative to institutional medical psychiatry, private, confidential and contractual psychotherapy, the only honest way, in his opinion, to deal with what he considers the real object of psychiatry, the ethical problems of life and not the supposed "mental illnesses". For Szasz, psychiatry is not part of medicine but of philosophy, sociology and psychology. Consequently, psychotherapy is much more of a rhetorical art than a medical technique.

In 1998, Szasz published a text entitled "Thomas Szasz's Summary Statement and Manifesto" (Szasz, 1998), a definitive statement of intent that summarizes the positions he held throughout his career as an intellectual. This manifesto can be considered an outline of his thinking:

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[60] "The psychiatric mandate to protect people from themselves (masturbation in the old days, drugs and suicide today) is at the heart of what I consider to be its intrinsically unscientific and morally problematic (to put it mildly) character. Today we are caught up in the consequences of this medicalization of moral or social 'problems' that we conceptualize as mental disorders and attempt to remedy with the drugs and coercions we call 'psychiatric treatments'."

Thomas Szasz's Summary Statement and Manifesto

1. *"Myth of mental illness."* Mental illness is a metaphor (metaphorical disease). The word "disease" denotes a demonstrable biological process that affects the bodies of living organisms (plants, animals, and humans). The term "mental illness" refers to the undesirable thoughts, feelings, and behaviors of persons. Classifying thoughts, feelings, and behaviors as diseases is a logical and semantic error, like classifying the whale as a fish. As the whale is not a fish, mental illness is not a disease. Individuals with brain diseases (bad brains) or kidney diseases (bad kidneys) are literally sick. Individuals with mental diseases (bad behaviors), like societies with economic diseases (bad fiscal policies), are metaphorically sick. The classification of (mis)behavior as illness provides an ideological justification for state-sponsored social control as medical treatment.

2. *Separation of Psychiatry and the State.* If we recognize that "mental illness" is a metaphor for disapproved thoughts, feelings, and behaviors, we are compelled to recognize as well that the primary function of Psychiatry is to control thought, mood, and behavior. Hence, like Church and State, Psychiatry and the State ought to be separated by a "wall." At the same time, the State ought not to interfere with mental health practices between consenting adults. The role of psychiatrists and mental health experts with regard to law, the school system, and other organizations ought to be similar to the role of clergymen in those situations.

3. *Presumption of competence.* Because being accused of mental illness is similar to being accused of crime, we ought to presume that psychiatric "defendants" are mentally competent, just as we presume that criminal defendants are legally innocent. Individuals charged with criminal, civil, or interpersonal offenses ought never to be treated as incompetent solely on the basis of the opinion of mental health experts. Incompetence ought to be a judicial determination and the "accused" ought to have access to legal representation and a right to trial by jury.

4. *Abolition of involuntary mental hospitalization.* Involuntary mental hospitalization is imprisonment under the guise of treatment; it is a covert form of social control that subverts the rule of law. No one ought to be deprived of liberty except for a criminal offense, after a

trial by jury guided by legal rules of evidence. No one ought to be detained against his will in a building called "hospital," or in any other medical institution, or on the basis of expert opinion. Medicine ought to be clearly distinguished and separated from penology, treatment from punishment, the hospital from the prison. No person ought to be detained involuntarily for a purpose other than punishment or in an institution other than one formally defined as a part of the state's criminal justice system.

5. *Abolition of the insanity defense.* Insanity is a legal concept involving the courtroom determination that a person is not capable of forming conscious intent and, therefore, cannot be held responsible for an otherwise criminal act. The opinions of experts about the "mental state" of defendants ought to be inadmissible in court, exactly as the opinions of experts about the "religious state" of defendants are inadmissible. No one ought to be excused of lawbreaking or any other offense on the basis of so-called expert opinion rendered by psychiatric or mental health experts. Excusing a person of responsibility for an otherwise criminal act on the basis of inability to form conscious intent is an act of legal mercy masquerading as an act of medical science. Being merciful or merciless toward lawbreakers is a moral and legal matter, unrelated to the actual or alleged expertise of medical and mental health professionals.

6. In 1798, Americans were confronted with the task of abolishing slavery, peacefully and without violating the rights of others. They refused to face that daunting task and we are still paying the price of their refusal. In 1998, we Americans are confronted with the task of abolishing psychiatric slavery, peacefully and without violating the rights of others. We accept that task and are committed to working for its successful resolution. As Americans before us have eventually replaced involuntary servitude (chattel slavery) with contractual relations between employers and employees, we seek to replace involuntary psychiatry (psychiatric slavery) with contractual relations between care givers and clients.

Thomas Szasz March 1998 (Szasz, 1998)[61].

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(61) "Summary Statement and Manifesto by Thomas Szasz

1. '*Myth of mental illness*.' Mental illness is a metaphor (metaphorical disorder). The word 'disorder' denotes a demonstrable biological process affecting living bodies or organisms (plants, animals and humans). The term 'mental illness' refers to undesirable thoughts, feelings and behaviors of people. To classify thoughts, feelings and behaviors as disorders is a logical and semantic error, as is classifying the whale as a fish. Just as the whale is not a fish, mental illness is not a disorder. Individuals with brain disease (bad brains) or kidney disease (bad kidneys) are literally sick. Individuals with mental disorders (bad behaviors), like societies with economic disorders (bad fiscal policies), are metaphorically sick. The classification of (mis)behavior as a disease provides ideological justification in the form of medical treatment for state-sponsored social control.

2. *Separation of psychiatry and the state*. If we recognize that 'mental illness' is a metaphor for the thoughts, feelings and behaviors we reject, we are obliged to recognize, likewise, that psychiatry's primary function is to control thought, mood and behavior. Therefore, like Church and State, psychiatry and State should be separated by a 'wall'. At the same time, the State should not interfere in mental health practices among consenting adults. The role of psychiatrists and mental health experts in relation to the law, the educational system and other organizations should be similar to the role of the clergy in such contexts.

3. *Presumption of competence*. Since being accused of mental illness is similar to being accused of a crime, we should presume that psychiatric 'defendants' are mentally competent, just as we presume that criminal defendants are legally innocent. Individuals charged with criminal, civil or interpersonal offenses should never be treated as incompetent based solely on the opinion of mental health experts. Incompetence would have to be a judicial decision and the 'accused' should have access to legal representation and the right to a jury trial.

4. *Abolition of involuntary psychiatric hospitalization*. Involuntary mental hospitalization is incarceration disguised as treatment, a covert form of social control that subverts the law. No one should be deprived of liberty except for cause for a criminal offense, after a jury trial guided by the legal standard of proof. No one should be locked up against his or her will in a building called a 'hospital' nor in

As can be seen, this is, first and foremost, a political statement of liberal ideology against the coercive practices of psychiatry. The only purely theoretical point is the first, which deals with the alleged mythical quality of the concept of "mental illness". On the other hand, Szasz devotes the last point of the "Manifesto" to defending, in tone

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no other medical institution as a result of expert opinion. Medicine should be clearly differentiated and separated from criminology, the treatment of punishment and the prison hospital. No person should be involuntarily detained except for the purpose of punishment, nor locked up in any institution other than that formally defined as part of the criminal justice system of the state.

5. *Abolition of the defense of insanity*. Insanity is a legal concept that implies a judicial decision that a person is not capable of forming a conscious purpose and, therefore, cannot held responsible for a criminal act. Expert opinions about the 'mental state' of defendants should be inadmissible court, just as expert opinions about the 'religious state' of defendants are inadmissible. No one should be exonerated from a crime, or any other offense, on the basis of so-called expert opinion offered psychiatric or mental health experts. Exonerating a person from responsibility for a criminal action based on his or her inability to form a conscious purpose is an act of pity masquerading as an act of medical science. Being pious or cruel to offenders is a moral and legal issue that has no bearing on the actual or purported expertise of medical and mental health professionals.

6. In 1798 Americans were confronted with the task of abolishing slavery peacefully and without violating the rights of others. They refused to face that daunting task and we are still paying the price for that refusal. In 1998, we Americans are faced with the task of abolishing psychiatric slavery peacefully and without violating the rights of others. We accept that task and pledge to work for its successful resolution. Just as those who came before us virtually replaced involuntary servitude (bondage) with contractual relationships between employers and employees, we seek to replace involuntary psychiatry (psychiatric slavery) with contractual relationships between professionals and their clients.

Thomas Szasz, March 1998".

something epic, his alternative proposal to institutional psychiatry: contractual psychotherapy. Thus, as will be seen in the following sections, Szasz's critique of psychiatry is flanked by his conceptual analysis as a basis, his contractual psychotherapy as an alternative, and his liberal ideas as a general frame of reference.

In order to clearly present Szasz's system of thought, I will divide this chapter into three sections: 1) Szasz, philosopher of psychiatry; 2) Szasz, liberal politician; and, 3) Szasz, theorist of behavior and psychoanalysis. I shall confine myself here to reporting what this author has said, while refraining from any interpretative work.

2.1. SZASZ, PHILOSOPHER OF PSYCHIATRY

Szasz's most important and best known work and the one that shook the edifice of institutional psychiatry in the early 1960s, *The Myth of Mental Illness. Foundations of a Theory of Personal Conduct* (Szasz, 1961b)[62] consists of two books which, although related, are clearly distinct. The first book is entitled *The Myth of Mental Illness* and includes six chapters grouped in two parts: "Growth and Structure of the Myth"; and "Hysteria: An Example of the Myth". In it, Szasz undertakes a philosophical analysis in which he questions the concept of mental illness and the foundations of mental illness.

[62]I take as reference the third edition of this book published in 1961 by Dell Publishing Company, which reproduces, without changes, the first edition published the same year by Hoeber-Harper. The translation into Spanish that I am including here is the one made by Flora Setaro for Círculo de Lectores, published in Barcelona in 1999. I will quote together the original reference and that of the translation.

scientific and methodological approaches to psychiatry. He concludes that mental illness is a myth, that psychiatry is a social science that deals not with diseases but with ethical problems of life and that, accordingly, its methodology should not be medical but psycho-social (psychotherapy). The second book is entitled *Foundations of a Theory of Personal Conduct* and consists of ten chapters grouped in three parts: "Semiotical Analysis of Behavior"; "Rule-Following Analysis of Behavior"; and "Game-Model Analysis of Behavior". In it, having reached the above-mentioned conclusions, Szasz wants to "offer a 'constructive' synthesis of the knowledge he considers useful to fill the void left by the myth of mental illness" (Szasz, 1961b, p. x; Transl.: 1999, pp. 34-35) and, thus, "lay the foundations of a theory of personal behavior in terms of processes [and not ideals]" (*Op.cit.*, p. 2; Transl.: 1999, p. 40).

In this first section I will delve into some articles that preceded *The Myth of Mental Illness* (1956-1961) and, fundamentally, into the first book of this work dedicated to philosophical questions. The second book, in which Szasz presents his way of understanding human behavior and in which he defends a new conceptualization of the so-called "mental illnesses" not as something that *happens* to people (like any other illness, a perspective defended by classical psychiatry) but as something that people *do* with a communicative intention, will be dealt with in the section dedicated to Szasz the psychotherapist.

In order to present Szasz's philosophical analysis of psychiatry, I will organize the information around three questions about the issues that have traditionally been the most important in psychiatry.

The following questions are of concern to the epistemologists of psychiatry: What is mental illness, what kind of science is psychiatry, and can psychiatry follow a medical model? These issues are closely related, so their separation under different headings is somewhat forced and has been done solely for reasons of structure. The following quotation shows the link between these issues and, in short, Szasz's main thesis in this respect:

> It is customary to define psychiatry as a medical specialty concerned with the study, diagnosis, and treatment of mental illnesses. This is a worthless and misleading definition. Mental illness is a myth. Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social, and ethical problems in living. [...] The notion of a person "having mental illness" is scientifically crippling. It provides professional assent to a popular rationalization, namely, that problems in human living experienced and expressed in terms of bodily feelings or signs (or in terms of other "psychiatric symptoms") are significantly similar to *diseases of the body.* It also undermines the principle of personal responsibility, upon which a democratic political system is necessarily based, by assigning to an external source (i.e., the "illness") the blame for antisocial behavior.
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> [...] Although powerful institutional pressures lend massive weight to the tradition of keeping psychiatric problems within the conceptual fold of medicine, the scientific challenge seems clear. The task is to redefine the problem of mental illness so that it may be encompassed under the general category of the science of man. (*Op.cit.*, p. 296-297).[63].

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(63) "It is common to define psychiatry as a medical specialty dedicated to the study, diagnosis and treatment of mental illnesses. This definition is useless and misleading. Mental illness is a myth. Psychiatrists do not deal with mental illness and its therapy. In practice they face vital social, ethical and personal problems.

[...] The idea that a person 'has a mental illness' is harmful from a scientific point of view, since it offers professional support to a popular rationalization that consists in believing that the experiential problems of a person's mental illness are not a mental illness.

Around 1960, Szasz openly raised fundamental questions that psychiatry has not yet been able to answer satisfactorily: Is "mental illness" an illness, is psychiatry a science like medicine, and can the mind be treated by medical procedures? According to Szasz, psychiatry does not allow itself to answer these questions with "no" since "to deny the validity of mental illness as an illness would deny the moral legitimacy of involuntary psychiatric interventions, the medical legitimacy of voluntary psychiatric interventions, and the economic legitimacy of psychiatric interventions considered treatments" (Szasz, 2001, p. 85). In other words, if it were demonstrated and admitted that mental illness is not an illness, the whole edifice of psychiatry as a medical specialty and as a social institution authorized to practice coercion under the protection of the ethics of care would fall (*Ibid.*).

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experienced and expressed in the form of feelings and bodily signs (or other 'psychiatric symptoms') are significantly similar to *organic diseases*. It also undermines the principle of personal responsibility (on which the democratic political system is necessarily based) by attributing blame for antisocial behavior to an external source (i.e. 'illness'). We know that, in the case of the individual patient, this attitude prevents a scrutinizing psychoanalytic approach to the problems that the 'symptoms' conceal and manifest at the same time.

[Although powerful institutional pressures lend massive support to the tradition of keeping psychiatric problems within the conceptual envelope of medicine, the scientific challenge is clear. The task is to redefine the problem of mental illness so that it can be included in the general category of the human sciences" (Transl.: 1999, pp. 444-445).

2.1.1. WHAT IS MENTAL ILLNESS?

> If I say that mental illness is a metaphorical illness. I am not saying that it is some other kind of illness; I am saying that it is not an illness at all (Szasz, 1987, p. 151). [64]

> My critics are fond of asserting that I "deny the reality of mental illness." [...] When I say that mental illness is not an illness I do not deny the reality of the behaviors to which the term points, or the existence of the people who exhibit them, the suffering the denominated patients may experience, or the problems they create for their families. I merely classify the phenomena phenomena people call "mental illnesses" differently than do those who think they are diseases (Szasz, 2001, pp. 114-115).[65]

Szasz considers disease to be an empirical phenomenon that can only be suffered by an object, a part of the body, which is treated by physicians with physico-chemical methods. Since the mind is not a part of the body, "mental illness" is not observable in the same way as a brain tumor or an inflammation of the liver. Therefore, the mind cannot be diseased in a literal sense, nor, therefore, can medical treatment be applied to it. In short, mental illness cannot be conceived from a medical-scientific point of view (Szasz 1956b, p. 304; 1958a, p. 187; Mitchell, 2009). Mental illness is, therefore

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(64) "When I say that mental illness in a metaphorical illness, I am not saying that it is some other kind of illness but that it is not an illness at all."

(65) "My critics love to claim that I 'deny the reality of mental illness'. [...] When I say that mental illness is not an illness, I do not deny the reality of the behaviors referred to by that term or that there are people who exhibit them, nor the suffering that so-called patients may experience, nor the problems they may cause their families. I simply classify the phenomena that people call 'mental illness' in a different way than those who consider them to be diseases.

on the contrary, a theoretical concept and a metaphorical resource[66] (Szasz, 1956b, p. 304; 1981, p. 393) that has been used for certain social purposes as an explanation of a great variety of phenomena in the same way that in ancient times the concepts of deity or witchcraft were used as evident causes of different events, a thought that was installed in society as an unquestionable truth even though there was no proof of it (Wyatt, 2004, p. 72-73). In this sense, the concept of "mental illness" has, in , a reassuring social function, as do religious and political myths. It is as useful a myth as the myth of the existence of witches was in its day.[67]As an example of this, Szasz turns to the psychiatrist and psychoanalyst Charles Rycroft who, although

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[66]See, , how Szasz defines the use of the metaphorical function:

"According to Aristotle, we use a metaphor when we give 'the thing a name that belongs to something else.' However, it is impossible to use language without using metaphor. We can eliminate metaphor, or cleanse our language of it, only at the cost of remaining silent. If we are going to employ language, either we must use metaphor consciously and be its master, or use it unconsciously and be its slave. Because metaphor is a powerful linguistic device for illuminating, as well as for obscuring, the character of an object, it is the stock-in-trade of the rhetorician. Most efforts to convince rest on the use of metaphor. The rhetorician's skill lies in convincing his audience that his metaphor is not of human making but an 'objective' description of 'reality.'" "Following Aristotle, we use a metaphor when we give 'to the thing a name that belongs to something else.' However, it is impossible to employ language without using metaphor. We can only eliminate metaphor, purify our language, at the cost of silence. If we are to use language, we can either use metaphor consciously and be its master or use it unconsciously and be its slave. Since metaphor is a powerful linguistic device for both illuminating and obscuring the nature of an object, it is the rhetorician's greatest resource. Most acts aimed at convincing make use of metaphor. The rhetor's skill lies in convincing his audience that his metaphor is not a personal construct but an 'objective' description of 'reality'" (Szasz, 1964, pp. 522-523).

[67]This is the historical hypothesis that Szasz defends in his book *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (1970).

asserting that mental illnesses are not illnesses but creations of the patient himself, recognizes that such a designation is a useful social fiction since otherwise it could not be treated. For Szasz, "to suggest that understanding neurosis as a mental illness is a 'useful fiction' is tantamount to confessing the moral decay of the profession" (Szasz, 2001, pp. 93-94).

Szasz opposes this self-indulgent and dangerous use of the term and the myth of mental illness and urges us to be more rigorous, to think a little more. The term "mental illness" comes from a metaphorical identification of certain behavioral phenomena with the symptoms of brain diseases already dealt with by neurology, such as the delusions that can appear in syphilis. For biologistic psychiatrists there is no such metaphor: "All the problems of life are attributed to physico-chemical processes which medical research will discover in due course" (Szasz, 1960a, p. 113). This perspective is based on a double error: a conceptual one by which it is claimed that mental illness is, in essence, no different from any other illness, and an epistemological one that turns a socially accepted *idea* into a scientifically unquestionable *truth*. Thus, according to this doubly erroneous conception, the psychiatrist is supposed to act with respect to mental illness following a scientific method similar to that employed by the traumatologist when repairing a bone. However, while an organic symptom is empirically ascertainable by any physician by the presence of very concrete events (physical signs) *occurring* in the patient's body, a psychic symptom, even if manifesting itself in the body, is something the patient *does* (Kerr, 1997, p. 42; Szasz 1981, p. 394), which implies a subjective act of communication to be judged by the psychiatrist on the basis of subjective and social conceptions and not on objective scientific evidence. This point of view is rejected by those psychiatrists who defend the biological origin of this

It is therefore difficult to understand how useful it is for them to use the concept "mental illness" when they should use, more appropriately and for greater clarity, the term "brain disease" or "of the nervous system" (Szasz, 1960a, p. 114). Therefore:

> If the mind were, in fact, the brain, there would be no justification for the existence of two separate medical specialties devoted to the diagnosis and treatment of diseases of the brain, neurology and psychiatry. If mental illnesses are brain diseases, they ought to be treated by neurologists and neurosurgeons (Szasz, 1996, p. 96).[68].

If, following the scientific method, objective evidence were found that mental illness has an organic etiology, for example, in the nervous system, mental illness would cease to be mental illness and be called neurological or cerebral illness; therefore, such illness would cease to be the object of psychiatry and would become the object of neurology. This shows that psychiatry, as a supposed medical specialty, maintains a very weak epistemological position (Mitchell, 2009).

Szasz does not deny that, in the future, certain aspects of our behavior may be causally correlated with brain lesions or dysfunctions. At that time, the now so-called "mental illnesses" would be diagnosable through objective scientific methods. Only then could we consider them genuine medical illnesses (Szasz, 2001, p. 105). Until then, the term "mental illness" was actually used to describe and identify certain characteristics of the which is called

(68) "If the mind were, in fact, the brain, there would be no justification for the existence of two separate medical specialties both dedicated to the diagnosis and treatment of brain diseases: neurology and psychiatry. If mental illnesses are brain diseases they should be treated by neurologists and neurosurgeons."

"personality." Now, Szasz asks, "what kind of behavior is considered indicative of mental illness and by whom?" (1960a, p. 114). If "the concept of illness, whether bodily or mental, implies a *deviation from a certain clearly defined norm*" (*Ibid*.), in the case of mental illness such deviation is not measured against a norm established in scientific terms (e.g., in relation to biological survival) but in terms of psychological, social, ethical, and legal concepts or, in other words, according to the way in which another or others consider that a person should govern his or her life and relate to others. The point is that, while bodily illnesses are objective physicochemical events, so-called mental illnesses are social phenomena in which the person who diagnoses them (psychiatrist) and his or her way of understanding life and social relations is involved. Szasz criticizes the tendency institutional psychiatry to deny the moral aspects of its practice and to assert, correspondingly, that its *medical* judgments are value-free (*Op.cit.*, p. 116): "By defining our moral, religious and social problems as manifestations of a 'mental illness,' psychiatry performs a rhetorical and not a scientific function" (Szasz, 1964, p. 527). He considers that it is not possible to solve an ethical problem in medical terms supposedly free of personal considerations. In practice there is, therefore, a hidden conflict between the real (ethical) conflict, its supposed (biological) etiology and the proposed remedy, ideally medical but, in practice, psychological, philosophical, social or legal (psychotherapy, internment in a psychiatric hospital, etc.) (1960a, p. 114).

On the other hand, Szasz warns of the risk of labeling people as mentally ill: in this way, the person may attribute his or her actions and problems to the supposed fact of being a victim of a "mental illness", in such a manner that the

individual responsibility is conveniently concealed (*Op.cit.*, p. 117). Mental illness is an exculpatory explanation, a way of evading the fact that people are ultimately responsible for their actions and decisions: "Mental illness is a myth whose function is to hide and make more digestible the bitter pill of moral conflicts in human relationships" (*Op.cit.*, p. 118).[69].

On this theoretical basis, Szasz undertakes a historical analysis of the origins of the concept of mental illness. The questions he poses are: "How did the study of so-called 'mental illness' begin and develop, what economic, moral, political, and social forces helped to shape it into its present form? And, perhaps more importantly, what effect did medicine, especially the concept of physical illness, have on the development of the concept of mental illness" (Szasz 1961b, p. 8; trans.: 1999, p. 49).

Szasz proposes the diagnosis of conversion hysteria[70]as a paradigm of so-called mental illness for the following reasons: on the historical level it was the problem that caused the pioneers to differentiate psychiatry from neurology; on the logical level hysteria poses the dilemma real (physical) illness and fake illness; and on the psychosocial level hysteria is a good example of what Szasz means by "mental illness":

a particular system of use of signs, of compliance with rules (helplessness),

[69]The question of the personal responsibility of the so-called "mentally ill" will be dealt with in greater detail in the fifth chapter. I anticipate that, from a clinical point of view, I consider Szasz's position in this regard to be highly debatable.

[70]Conversion hysteria was a very popular disorder at the end of the 19th century, characterized by the presence of behavioral symptoms resembling (conversion) those of a neurological disease but lacking etiology and physical explanation. This disorder attracted the interest of eminent neurologists such as Jean-Martin Charcot, Pierre Janet, Josef Breuer and Sigmund Freud.

and coercion) and of participation in the disease game whose goals are domination and interpersonal control (*Op.cit.*, pp. 8-9; Transl.: 1999, pp. 49-50).

Psychiatry began to be interested in the so-called functional diseases, such as hysteria, included in the category of structural diseases (physical, real) and differentiated from the false diseases considered as feigning. It was assumed that the mentally ill person did not act in this way at will, as was the case with the pretender (*Op.cit.*, p.p. 10-11; Transl.: 1999, pp. 52-53). Charcot called hysterical those subjects who showed signs of a neurological disease without suffering from it and elevated them to the category of patients, differentiating them, for the first time, from mere simulators and thus gaining greater social credit for them and for their physicians. Szasz refers to a quotation from Freud in which he points out this turning point: "Since Charcot, with all the weight of his authority, had pronounced himself in favor of the reality and objectivity of hysterical phenomena, it could no longer be considered a pretence" (Freud quoted by Szasz *op. cit.*, p. 25; trans. 1999, p. 71).[(71).]

Szasz considers that Charcot's act marks, on the one , "the modern beginning of the study of so-called mental illnesses" and, on the other hand, "contains what I consider to be the main logical and procedural error of modern psychiatry", namely, calling the previously faking sick and, with it, considering psychiatry a branch of medicine (*Op.cit.*, p. 26; Transl.: 1999, pp. 71-72). This allowed, from then on, that faking illness was more profitable than before, leaving both doctor and patient satisfied "with a still very unsatisfactory state of affairs" (*Op.cit.*, p. 27; Trans.: 1999, p. 73).

[71]The quotation corresponds to the obituary that Freud dedicated to Charcot in 1893 (Freud, 1983, p. 34).

By advocating that hysteria was a disease, Charcot sought to gain scientific prestige for himself even at the cost of hiding his own observations. This concealment maneuver is what Szasz calls the "double standard in psychiatry". To exemplify this phenomenon, Szasz turns again to Freud who relates what he thought when he heard Charcot comment on a case of hysteria at an informal meeting:

> Charcot suddenly broke in with great animation, *"Mais, dans des cas pareils c'est toujours la chose genitale, toujours toujours";* [...] and said to myself, "Well, but if he knows that, why does he never say so?" But the impression was soon forgotten; brain anatomy and the experimental induction of hysterical paralyses absorbed all available interest (Freud quoted by Szasz, *Op.cit.*, pp. 31-32).[(72)].

The double standard of psychiatry was established from the moment Charcot himself "held the medical point of view in public, for official purposes, to speak, and only defended the psychological approach in private, where such views were not dangerous" (*Op.cit.*, p. 34; trans.: 1999, p. 83). The danger was, evidently, the loss of psychiatry's coveted scientific-medical status. The point is, Szasz, that this fear prevents psychiatrists from assuming their true professional identity and orienting their work in a scientifically honest way, i.e. treating the existential problems of their patients as social-ethical and not medical issues.[73]

[(72)] "Charcot replied vividly: '*Mais, dans des cas pareils, c'est toujours la chose genital, toujours... toujours*' ['But, in cases like this, it is always the genital thing, always... always'] [...] and I said to myself: 'But, if you know it, why do you never say it?'. However, I soon forgot this impression; brain anatomy and the experimental induction of hysterical paralysis absorbed all my interest" (Transl.: 1999, p. 79). The text to which Szasz refers is "History of the Psychoanalytic Movement" (Freud, 1972, p. 1899).

[73]This issue will be developed in the fourth chapter.

In Charcot's and Freud's time, three types of cases were considered: the physically ill, the mentally ill (unconscious) and the pretenders (conscious). Over time, this last category also came to be considered mental illness, as Szasz refers to when quoting Bleuler[74]: "Almost all those who simulate insanity with some skill are psychopaths, and some are really insane. Therefore, proving that simulation exists in no way proves that the patient is mentally healthy and responsible for his actions" (Bleuler quoted by Szasz *op. cit.*, p. 48; trans. 1999, p. 102).

In what Szasz calls "the original medical game", the physician dealt exclusively with organic diseases and did not accept to treat *false diseases*. "The step taken by Charcot and implemented by Freud [...] alters the situation by changing the rules of the game" (*op. cit.*, p. 41; trans.: 1999, p. 92). By virtue of this, pretenders were considered mentally ill, which allowed them to enjoy the privileges of this new status (care, understanding, etc.) and physicians, as experts in diseases, were considered the specialists authorized to deal with them. Thus, "the prestige and power of psychiatrists increased as the domains within the sphere of their specific discipline were constantly widening" (*Op.cit.*, p. 43; Transl.: 1999, p. 96).

He states that "one of Freud's main contributions to medicine, psychiatry and social order lies in the creation of new rules of human behavior" (Szasz, 1961b, p. 42; trans.: 1999, p. 93). He assumes that Freud was not aware of this reclassification nor of its profound repercussions, the first of which was the *psychiatrization* of everyday life: "Physicians, and especially psychiatrists, began

[74]Bleuler, E. (1924), *A Textbook of Psychiatry*.

to call 'illness' (that is, of course 'mental illness') everything that would allow the detection of any sign of dysfunction on the basis of any kind of norm", as happened, for example, with supposed illnesses such as homosexuality (*Op.cit.*, p. 45; Transl.: 1999, pp. 97-98).

Far from disappearing, this tendency to include different forms of life in the catalog of diseases continued to increase over time: "Psychiatrists have 'created' some very famous diseases for which they have never apologized" (Wyatt, 2004, p. 74). In practice, Szasz considers applying medical therapies (e.g., prescribing drugs) to phenomena that have not been shown to be diseases (e.g., attention deficit hyperactivity disorder (ADHD) in children) to be a highly irresponsible psychiatric act (Sullum, 2000) that has been endorsed by the political establishment, as evidenced by the declaration of the 1990s as the Decade of the Brain (Bush, 1990), a slogan that, for Szasz, is "a coded expression to promote the belief that mental illnesses are brain diseases and thus to justify the government's unstoppable economic funding of the fight against these 'diseases'. [...] The statement that 'serious' mental illnesses are brain diseases can no longer be questioned. It is a fact" (Szasz, 1996, p. 97). In this regard, he gives several examples of statements by prominent members of U.S. governments, including some presidents, or by top officials of American mental health institutions or university professors exclaiming loud and clear that mental illnesses are physical illnesses that must be treated medically (Szasz, 2001, pp. 86 and 125-126; 2008, p. 89). Szasz ironizes in this regard: "It seems that it has not occurred to people or the media to question why only mental illnesses need justification from the White House" (*Op.cit.*, p. 86). In doing , Szasz points to the

political and economic interests behind the alliance between psychiatry, the State and pharmaceutical companies, which I will discuss in another section.

2.1.2. WHAT KIND OF SCIENCE IS PSYCHIATRY?

In the late 1950s, Szasz set out to conduct an investigation of the differences between medicine and psychiatry in relation to their framework of knowledge, their methods of intervention, and the social role occupied by their respective professionals (Szasz 1958b, p. 228). He considers that this interrogation is not a direct contribution to either of these disciplines (although it is of great theoretical and practical relevance to them) but to the philosophy of medicine and psychiatry (*Op.cit.*, p. 229).

Originally, psychiatry was regarded with suspicion by medicine. However, by the middle of the 20th century, psychiatry managed to establish itself as another branch of medicine. Psychiatrists succeeded in convincing the world that mental illnesses were real diseases that should be treated with medical methods. However, says Szasz, the *problems of life* do not have the same origin as illnesses of the body, nor does psychotherapy, which is the most common method of solving them, have anything to do with medicine: "We must unequivocally recognize that psychiatry has more similarities with religion and politics than with science" (Szasz 1961b, p. 85; trans. 1999, p. 153). This tendency not to recognize the capabilities and limits of psychiatry by disguising it in medical garb undermines its scientific integrity (Szasz, 1961a, p. 64 and 1957c, p. 447). In support of this thesis,

Szasz draws on the words of physicochemist and philosopher of science Michael Polanyi for whom:

> The recognition of certain basic impossibilities has laid the foundations of some major principles of physics and chemistry; similarly, recognition of the impossibility of understanding living things in terms of physics and chemistry, far from setting limits to our understanding of life, will guide it in the right direction (quoted by Szasz, 1996, pp. 90-91).

Precisely in order to protect the scientific integrity of psychiatry, Szasz proposes a serious analysis of its epistemological foundations in order to relocate it to the place that, in his opinion, corresponds to its object of study, the behavior of people: the human and social sciences.

> In order to secure the scientific advances that have been made in our field, I believe we could do no better than to recast our knowledge in a psychosocial, linguistic, and ethical framework. This would entail a re-emphasis of the differences, rather than the similarities, between man the social being and man the mammal. It would also result in abandoning the persistent attempts to convert psychologists and sociologists to biologists (physicians) or physicists, and they themselves would no longer need to aspire to these roles. The integrity of the science of man as social being thus requires -just as does the integrity of the individual- a forthright recognition of its historical origins together with an accurate assessment of its individual unique characteristics and potentialities. It is in this way, and not by imitating the greatness of the older, more securely established sciences, that the psychosocial disciplines must establish their rightful place among the sciences (Szasz, 1961a, p. 65).[75]

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(75) "In order to guarantee the scientific progress achieved in our field, I believe that we could do no better than to restructure our knowledge in a psychosocial, linguistic and ethical frame of reference. This

Therefore, the research, theory and methodology of psychology, although legitimately scientific, do not belong to the natural sciences. Szasz advocates "abandoning the whole medical-physicalistic approach to mental illness, replacing it with new perspectives and theoretical models adapted to psychological, ethical and social problems" (Szasz, 1961b, p. 84; Transl.: 1999, p. 151). He thus rejects the radical organicist materialism applied to mental illnesses initiated in the 19th century by the neurologist Carl Wernicke, for whom every mental disorder *is* a brain disease. In the absence of conclusive scientific evidence of the organic origin of mental illness, Szasz opts for the perspective of Isaiah Berlin for whom:

> In the course of this [explaining human behavior in causal-deterministic terms] they [the materialists] describe the normal lives lived by men in terms which fail to mark the most important psychological and moral distinctions known to us. This they do in the name of an imaginary science; and, like the astrologers and soothsayers whom they have succeeded, cast up their eyes to the clouds, and speak in immense unsubstantiated images and similes, in deeply misleading metaphors and allegories ... Thereby they throw dust in their own eyes as well in ours, obstruct our vision of the real world, and further confuse an already sufficiently bewildered public (quoted by Szasz, 1996, p. 90).

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would imply re-emphasizing the differences, rather than the similarities, between the person as a social being and as a mammal. It would also lead to abandoning continued attempts to transform psychologists and sociologists into biologists (physicians) or physicists. Thus, they would finally cease to aspire to occupy such roles. The integrity of the sciences of the human being as a social being (and as an individual) requires, therefore, a sincere recognition of its historical origins and a rigorous evaluation of its particular characteristics and potentialities. Only in this way, and not by imitating the greatness of the older and better established sciences, should the psychosocial disciplines claim their rightful place among the sciences".

Szasz does not deny that the organic may have some influence on behavior, but states that, in most psychological matters, this influence is minimal or non-existent (Szasz 1961b, p. 91; trans. 1999, pp. 161-162). What he resolutely opposes is the claim, based on pure belief, that mental illness is an illness like any other and that psychiatry is a natural science. So did Freud himself who "in a short essay written shortly before his death [...] reiterated that 'psychology is also a natural science [*Naturwissensenschaf*]. What else can it be?' The answer [says Szasz], especially in German, is totally obvious: a *Geisteswissensenschaft* (Szasz, 2008a, p. 49).[76]

In short, Szasz considers that the psychological problems of the human being are ethical and not medical: "The laws of psychology cannot be formulated without taking into account the laws of sociology" (Szasz, 1961b, p. 7; Trans.: 1999, p. 48). He advocates a non-exclusive approach, an open approach that:

> Will effect a much-needed and long overdue *rapprochement* between psychiatry on the one hand and philosophy and ethics on the other. [...] Psychology -and psychiatry, as a branch of it- was closely allied to philosophy and ethics until the latter part of the nineteenth century. Since then, psychologists have considered themselves empirical scientists whose methods and theories are allegedly no different than those of the physicist or biologist. [...] Psychiatrists cannot expect to solve ethical problems by medical methods (*Op.cit.*, p. 8).[77]

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[76]The text of Freud to which Szasz refers is "Some Elementary Lessons in Psychoanalysis" (Freud, 1975, p. 3420).

(77) "I achieved a much needed and long overdue *rapprochement* between psychiatry, on the one hand, and philosophy and ethics, on the other. [...] Psychology (and psychiatry, as a branch of psychiatry) maintained a close relationship with philosophy and ethics until the late 19th century. Since then, psychologists have

Szasz's determined attack on psychiatric materialism at the beginning of his career takes on special meaning from 1980 onwards, when the boom in neuroscientific research aimed at demonstrating the cerebral origin of mental disorders, the promotion of medical diagnostic manuals and the proliferation of pharmacological treatments that are still in force today, began. He asserts (as demonstrated by many current scientists that I will cite in the fourth chapter) that such research has not proven the etiological hypothesis that considers the mind and the brain as equivalent, that the elaboration of diagnostic manuals is far from following scientific criteria and that drugs do not have the "curative" effect that their promoters (pharmaceutical companies, researchers, psychiatrists, politicians, etc.) claim they have. Szasz considers that true scientists require solid evidence to determine the etiology of a disease but, on the contrary, psychiatrists accept any materialistic (though unproven) explanation of the biological origin of "mental illness". He considers that the historical assertion (without scientifically proven evidence) that mental illnesses are diseases of the brain is not science but scientism, a materialistic ideology that the scientific community and the public unconditionally accept as truth (Szasz, 2001, p. 104; 1996, pp. 92-93; 1987, p. 90-91). As an example of this, he comments on the words of neuroscientist and Nobel laureate in medicine Francis Crick:

> In a book titled *The Astonishing Hypothesis* he [Francis Crick] argues that "'you,' your joys and your sorrows, your memories and your ambitions, your sense of personal identity and free will, are in fact no more than the behavior of vast assembly of nerve cells and their associated molecules. [...] Each of us *is* the behaviors of a vast, interacting set of neurons." If Crick

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considered empirical scientists and their methods and theories are not supposed to differ from those of the physicist or the biologist. [Psychiatrists cannot expect that the possibility of solving ethical problems by means of methods corresponding to the field of medicine will be fulfilled" (Transl.: 1999, pp. 48-49).

thinks this is a new idea, it is because he is ignorant of the history of the mind and especially of the history of madness. Hippocrates (fourth century, B.C.) had already asserted that the mind is a function of the brain, a facile equation that never lost its appeal. In 1819, as modern medicine was aborning, Sir William Lawrence (1783-1867), President of the Royal College of Surgeons, declared: "The mind, the grand prerogative of man, [is] merely an expression of the function of the brain." Crick insists that [...] free will is located in or near the anterior cingulate sulcus" (Szasz, 1996, p. 84).[78].

For Szasz the advocates of materialism in psychiatry are partly right since "there can be no identity or thought without a natural substratum. But, in essence, they are wrong since they cannot offer a materialistic explanation of language and even less of human existence as a personal experience" (*Op.cit.*, p. 76). As I will show in the fourth chapter, current critics of psychiatry such as Germán Berrios hold the same principle.

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(78) "In a book entitled *The Astonishing Hypothesis* [1994], [Francis Crick] argues that "You', your joys and your sorrows, your memories and your ambitions, your sense of personal identity and free will, are in fact nothing more than the action of a vast assemblage of nerve cells and their associated molecules. [...] Each of us is the action of a vast assemblage of interacting neurons'. If Crick thinks this is a novel idea it is because he is ignorant of the history of the mind and, especially, the history of madness. Hippocrates (fourth century B.C.) already stated that the mind is a function of the brain, a simple equation that never lost its appeal. In 1819, at the birth of modern medicine, Sir William Lawrence (1783-1867), president of the *Royal College of Surgeons*, declared: 'The mind, the great privilege of the human being, [is] only the expression of brain function. Crick insists that [...] free will is located in, or near, the anterior cingulate sulcus."

2.1.3. SHOULD PSYCHIATRY FOLLOW A MEDICAL MODEL?

> Many people -in and outside of the mental health professions- now assume that insanity is a brain disease and thus take it for granted that its explanation must be sought in neurobiological terms. In this way, the presumption that behavior denominated as mental illness is the manifestation of disordered brain function determines -prejudges perhaps is more accurate- not only what counts as *understanding* such behavior but also what counts as *trying to understand it.* This is why my criticisms of the neuropathological and psychopharmacological fakeries of psychiatry are often misinterpreted as opposition to "research about how the brain works" -an absurd contention. My objections to the claims of organic psychiatrists lie elsewhere, in what I consider to be two fundamental misconceptions: one is a misunderstanding of the differences between the literal and metaphorical meanings of words; the other is a misunderstanding of the relationship between chemical processes in the body and human experiences or so-called mental states (Szasz, 1987, pp. 344-345).[79]

If, in , there is broad agreement among scientists, it is because they handle objective data that limit the multiplication of theories. However, the disagreement

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(79) "Today, many people (inside and outside the mental health professions) assume that insanity is a mental illness and, therefore, take it for granted that its explanation must be reached with neurobiological methods. Thus, the assumption that behavior termed mental illness is the manifestation of the functioning of a diseased brain determines (prejudges is, perhaps, more accurately) not only the understanding of such behavior but also *the attempt to understand it*. This is why my criticism of the neuropathological and psychopharmacological fallacies of psychiatry are often misconstrued as opposition to 'brain functioning research', which is an absurd claim. My objections to the claims of organicist psychiatrists are based on what I consider to be the two fundamental confusions: one is to confuse the literal meaning of words with the metaphorical; the other is to confuse the chemical processes of the body with the human experiences called mental states."

among psychiatrists is permanent and "psychiatric theories are almost as numerous and varied as psychiatric symptoms" (Szasz 1961b, p. 86; Transl.: 1999, p. 153). There is a great lack of consensus among psychiatrists about what mental illness is and how to treat it (Szasz, 1958a, p. 187). This discrepancy does not occur in any other branch of medicine, for example, in neurology, whose object, brain disease, can be scientifically investigated, observed, diagnosed and intervened by scientific methods.

By "scientific method" Szasz means those particular technical procedures that are employed in each discipline (Szasz 1958b, p. 229). In the case of medicine, the method consists in the examination of the human body, for which certain technologies are used in order to reach an objective diagnosis and to apply the technical treatments that have proven to be effective, such as surgery or the administration of chemical substances: "Medicine deals with the human (and animal) body as a physicochemical machine. Accordingly, the methods employed by physicians derive from physics and chemistry" (*Op.cit.*, p. 230). Some psychiatrists consider their object of study and intervention to be brain diseases and, as other physicians would do, employ (or have employed) specific techniques such as electroshock, drugs and surgery. However, for Szasz, diseases of the brain, as part of the body, are not the object of psychiatry but neurology. On the other hand, the true object of psychiatry is the person as a social being and its methods of intervention are psychosocial (derived from psychology, sociology and philosophy) carried out mainly through verbal communication (*Op.cit.*, p. 230). Therefore, physicians should practice medicine and psychiatrists should practice psychotherapy.

> Psychiatry and neurology are not sister sciences, both belonging to the superordinate class called medicine. [...] Neurology is concerned with certain parts of the human body and its functions *qua* objects in their own rights-not as signs of other objects. Psychiatry (as defined here) is expressly concerned with signs *qua* signs-not merely with signs as things pointing to objects more real and interesting than they themselves (Szasz, 1961b, p. 51).[80].

Although, in some very specific aspects of his practice, the physician may be moved by his ethical principles (e.g., in cases of abortion, euthanasia, etc.), all psychiatric practice, understood as that which deals with problems in life and not with neurological problems, is always compromised by the psychiatrist's beliefs and values (Szasz, 1960a, p. 116).

Those psychiatrists who claim to act medically on illnesses as real and objective as bodily illnesses implicitly convey the idea that mental illness is similar, for example, to an infection. If this were so, one could catch or spread mental illness. However, Szasz argues that:

> In my opinion, there is not a shred of evidence to support this idea. To the contrary, all the evidence is the other way and supports the view that what people now call mental illnesses are

(80) "Psychiatry and neurology are not [...] two sister sciences belonging to the higher order class we call medicine. [...] Neurology deals with certain parts of the human organism and their functions *qua* objects in their own right, *not* as signs of other objects. Psychiatry, as we define it here, deals expressly with signs *qua* signs, and not merely with signs that point to objects more real and interesting than the signs themselves" (Trad.: 1999, p. 106).

for the most part *communications* expressing unacceptable ideas, often framed, moreover, in an unusual idiom (*Op.cit.*, p. 116).[(81).]

The psychiatrists' disease-affirming rituals have varied from time to time. Today, psychiatrists proclaim the reality of mental illness by worshiping at the altar of neurobiolology and pychopharmaco-mythology and by speaking the language of brain disease, chemical imbalance, neurotransmitters, and psychopharmacology. In fact, the history of psychiatry from 1850 to the present is essentially the history of changing psychiatric fashions-from neuropathology to psychoanalysis to psychopharmacology. [...] Although psychiatrists and their supporters maintain that mental illnesses are brain diseases, they actually no longer rest their claims for psychiatry's power to cure disease or control dangerousness on adducing evidence of demonstrable pathological lesions, subject to verification and falsification. Instead, they base their claims on the authority of medical experts and political leaders, supported by "biological markers" of abnormal brain activities, exemplified by images obtained by means of positron emission tomography (PET) and other imaging techniques. However, even if the claim that a particular mental illness is the manifestation of a true brain disease were valid, it would establish only the presence of a new brain disease, not the validity of the concept of mental disease. That is what happened when certain types of madness suspected of being manifestations of brain diseases were shown to be *proven brain diseases*: for example, paresis and epilepsy ceased to be mental diseases and became instead infectious and neurological diseases (Szasz, 2001, p. 85).[82]

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(81) "In my opinion, there is not a shred of evidence to support this idea. On the contrary, the evidence is entirely on the other side and supports the view that what people call mental illnesses are, for the most part, communications expressing unacceptable ideas, often spoken in a strange language."

(82) "The rituals by which psychiatrists affirm illness have varied over time. Today, psychiatrists proclaim the reality of mental illness by praising the altar of neurobiology and *psychopharmacomitology* and chanting the language of brain disease, chemical imbalance, chemical

Szasz considers that psychiatric diagnoses have no justification from a scientific point of view. They are judgments formulated by the psychiatrist about the patient's behavior and not medical syndromes as they are usually presented in psychiatric writings (Szasz 1956, p. 442). He raises a critique of psychiatric nosology from the philosophical perspective of operationalism "which emphasizes the importance of clarifying the particular methods of observation employed in each investigation" (Szasz, 1957d, p. 410). If the psychiatrist's main source of information is the patient's own account of his or her symptoms, how can he or she know that the patient is not lying? This is contrary to any medical practice whose first function, the diagnosis of illness, requires prior objective evidence (cf. Sullum, 2000 and Wyatt, 2004, p. 77).

Unlike in medicine, psychiatric diagnoses of mental phenomena are completely subjective. In an arbitrary and self-interested way, the

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neurotransmitters and psychopharmacology. In fact, the history of psychiatry from 1850 to the present is, in essence, the history of the change in psychiatric fashions (from neuropathology, to psychoanalysis and psychopharmacology). [...] However, psychiatrists and their followers who maintain that mental illnesses are brain diseases do not, in fact, sustain their claims about psychiatry's ability to cure illness or to control dangerousness by claiming evidence of demonstrated pathological lesions subject to verification and falsification. Instead, they base their claims on the authority of expert physicians and political leaders who rely on 'biomarkers' of abnormal brain activities exemplified in images obtained by positron emission tomography (PET) and other imaging techniques. However, the assertion that a certain mental illness is the manifestation of a real brain disease would only confirm the presence of a new brain disease and not the validity of the concept of mental illness. This is what happened when certain types of insanity (suspected to be manifestations of brain diseases) were presented as proven brain diseases. For example, paresis and epilepsy ceased to be mental diseases and became infectious and neurological diseases."

psychiatrists grant the category of illness to mental disorders (behaviors that deviate from an established cultural norm). Thus, psychiatry invents its own diseases outside of any scientific method, which is not the case in any other branch of medicine. Since mental illness lacks objective evidence, psychiatrists, with their diagnoses, medicate problems of everyday life (Szasz, 1981a, p. 394; Kerr, 1997, p. 2).

> Psychiatrists maintain that our understanding of mental illnesses as brain diseases is based on recent discoveries in neuroscience, made possible by imaging techniques for diagnosis and pharmacological agents for treatment. This is not true [...] There are no objective diagnostic tests to confirm or disconfirm the diagnosis of depression; the diagnosis can and must be made solely on the basis of the patient's appearance and behavior and the reports of others about his behavior. The absence of objective diagnostic tests does not negate the validity of the psychiatric diagnosis; instead, the diagnosis affirms the validity of psychiatry as a medical specialty (Szasz, 2001, pp. 80-81).[83].

If psychiatric nosology drags historical difficulties and does not satisfy everyone, says Szasz, it is because previously there was no serious analysis of the question of whether psychiatry is, by its object of study and intervention, a branch of medicine or, rather,
of psychology and sociology. If the psychiatric diagnostic system does not work, it is because

(83) "Psychiatrists argue that our knowledge of mental illnesses as brain diseases is based on recent discoveries in neuroscience that have made possible diagnosis by imaging techniques and treatment by pharmacological agents. This is not true. There are no objective diagnostic tests that confirm or reject the diagnosis of depression. The diagnosis can and should only be made on the basis of the patient's appearance, behavior and the reports of others about such behavior. The absence of objective diagnostic tests does not negate the validity of the psychiatric diagnosis; rather, it confirms the validity of psychiatry as a medical specialty."

aims to classify, as if they were natural entities, matters relating to how people live and how they relate to others, thus constructing a medically based psychopathological system to categorize matters of an ethical nature (Szasz, 1957d, 405-406).

Psychiatry borrowed from medicine the concepts of normality and abnormality and applied them to behavior and its supposed organ, the "mind" (Hollender and Szasz, 1957, p. 599). However, while a medical diagnosis is usually devoid of moral charge (suffering from pneumonia does not imply the patient's loss of social status), a psychiatric diagnosis, especially that of psychosis, leads to the social denigration of the affected person (*Op.cit.*, p. 600). From the scientific-medical point of view to which psychiatry wants to ascribe itself, the terms "normal", "neurosis" and "psychosis" have little relevance. Instead of establishing generalist psychiatric diagnoses (as is done in medicine), these should be adjusted, with a particular meaning, to the concrete circumstances of each individual (*Op.cit.*, 606-607). Szasz points out that "making a specific diagnosis always involves inferring from observations" (Szasz 1961b, p. 70; Transl.: 1999, p. 172). Thus, he differentiates observations of regularities (scientific causation) from inference from them (diagnosis). Diagnosis can be erroneous if the observations are misleading, as is often the case in psychiatry where there are no objective methods to prove the veracity of the complaint or its causes. That is why psychiatric diagnosis rests on precarious bases (*Op.cit.*, p. 71; Transl.: 1999, pp. 172- 173).

He criticizes the use of psychiatric diagnoses as *panchrestons* (Hardin,1956), that is, as nouns that pretend to explain everything but fail to explain anything.

This is what happens with the word "schizophrenia" with which psychiatrists, in an attempt to fill a knowledge gap, not only fail to explain the phenomenon in question, but also make it difficult to understand. Instead of putting forward generalizing and insufficient concepts, Szasz believes, we should seriously redefine them, taking into account their multiple meanings, and establish different methodological lines, both biological and psychological, with a view to explaining the particular facts of the phenomenon. Biological research would show the possible physical origin of some psychoses while psychological research would shed light on the use of language, the formation of symbols and other behaviors characteristic of certain so-called schizophrenic patients. Even so, it would be illusory to claim that such studies would fully explain schizophrenia, we would only understand it better (Szasz, 1957d, 409-410).

Szasz quotes philosopher K.W.M. Fulford, for whom "the success of these [diagnostic] classifications is the direct result of the adoption of a descriptive approach that emulates [...] the scientific basis of disease classification in physical medicine". For Szasz, this need to *emulate* medicine is clear evidence that neither psychiatry is medicine nor mental illness is an illness (Szasz, 2001, p. 117).

He denounces and demonstrates that the inclusion and exclusion of diagnoses in the manuals (specifically, the *DSM*) does not follow any scientific but rather political criteria (Szasz, 1987, pp. 79-80; 2001, p. 94). In spite of this, psychiatrists continue to affirm the scientificity of such methods and the public continues to consider psychiatry as part of medicine:

One of the invited psychologists [to the 1985 *APA* meetings at which the revision of DSM-III and the inclusion of new diagnoses were discussed] -naively expecting something scientific to happen- complained: "The low level of intellectual effort was shocking. Diagnoses were developed by majority vote on the level we would use to choose a restaurant." [...] However, it does not seem to matter how openly political -how obviously nonmedical and unscientific- are the ways and means by which psychiatrists create categories of mental illness: the medical and scientific community, as well as the lay public, continue to view psychiatry as a bona fide medical specialty and mental illness as bona fide illness. Carol Nadelson, the president of the APA (for 1985-1986), smugly asserts: "Thanks to the use of DSM-III, the diagnosis of mental disorders is now generally as reliable as the diagnosis of physical ills. [...] Psychiatry has emerged as a mature medical specialty whose methods of diagnosis and treatment are guided by a rational scientific approach. Psychiatry has proved itself in the laboratory" (Szasz, 1987, pp. 80-81).[84]

Psychiatric News (the American Psychiatric Association's biweekly newspaper) asked: "does LLPDD [late luteal phase dysphoric disorder] exist?" The same question might be raised

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(84) "One of the psychologists invited [to the 1985 *APA* meetings discussing the revision of *DSM-III* and the inclusion of new diagnoses] (naively expecting something scientific to happen) lamented: 'It was shocking how low the level of intellectual effort was. The diagnoses were proclaimed by majority in the same way we would choose a restaurant'. [...] However, it does not seem to matter how clearly political (how obviously non-medical and unscientific) are the ways and means by which psychiatrists create the categories of mental illness: the medical and scientific community, as well as the lay public, continues to regard psychiatry as a genuine medical specialty and mental illness as a genuine disease. Carol Nadelson, president of the *APA* (1985-1986), smugly declares: 'Thanks to the use of *DSM-III*, the diagnosis of mental disorders is today, in general, as reliable as the diagnosis of physical illnesses. [Psychiatry has emerged as a mature medical specialty whose methods of diagnosis and treatment are guided by a rational and scientific approach. Psychiatry has been demonstrated in the laboratory".

about every nonbodily disease. The reporter then cites the comment of several psychiatrists that dramatically show psychiatry's intellectual bankruptcy and moral desolation: "The decision as to whether or not LLPDD will be assigned its own diagnostic category in the fourth edition of the APA's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* is 'a political land mine,' according to Allan Frances, M.D., chair of the Task Force on *DSM- IV*." David Rubinow, M.D., a psychiatrist who "has done research at NIH on PMS [premenstrual syndrome] for more than a decade," offered his opinion: "As far as I am concerned, the decision to include PMS in *DSM-IV* will be made on political rather than medical considerations" (Szasz, 1993, p. 7).[85]

Based on these and many other similar pieces of evidence, Szasz claims that "modern psychiatry [...] is a monument to quackery on a scale unimaginable in the annals of medicine" (Szasz, 2008, pp. 18-19). He considers that the motivation of the *American Psychiatric Association* (the organization that created the *DSM III* diagnostic manual and subsequent versions) is purely political: to demonstrate that psychiatrists are real doctors who diagnose real illnesses. However, "real doctors do not have to look for illnesses. They, and the patients who suffer from them, find them very often.

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(85) "*Psychiatric News* (the bimonthly journal of the *American Psychiatric Association*) asked: 'Is there such a thing as LLPDD [Late Luteal Phase Dysphoric Disorder, or Premenstrual Dysphoric Disorder]?' The same question could be asked about any non-bodily disorder. Then, the journalist quotes the comments of several psychiatrists that radically show the intellectual bankruptcy of psychiatry and its moral devastation: 'The decision of whether or not LLPDD should possess its own diagnostic category in the fourth edition of the *APA'*s *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*), 'is a political landmine' according to Allen Frances, head of the *DSM-IV* working group.' David Rubinow, a psychiatrist who 'has done research at the *NIH* [*National Institutes of Health*] on PMS [premenstrual syndrome] gives his opinion: 'As far as I am concerned, the decision to include PMS in *DSM-IV* will be made under political rather than medical considerations."

before. This is not so in psychiatry" (Szasz, 1993, p. 38). He quotes the words of Allen J. Frances, who states that the *DSM IV* is a manual of mental disorders, although it is not at all clear what exactly a mental disorder is. Moreover, Frances points out that the word "mental" implies a completely outdated mind-body dichotomy. So, asks Szasz, why is such a term "mental disorder" used, and why does the catalog of "mental disorders" grow with each edition of the manual instead of shrinking (2001, p. 78)? (2001, p. 78). Perhaps, he answers, because currently "no psychiatric hospitalization or treatment, no claim for reimbursement for psychiatric services rendered or for psychiatric disability, no warrant for detention, no allegation of alienation is valid unless it is supported by a corresponding *DSM IV* diagnosis" (Szasz, 2001, p. 80).

On the other hand, in 1957 Szasz already warned of the social and personal consequences of prescribing psychotropic drugs (specifically, antipsychotics) which he called "chemical straitjackets", a term that was later used profusely critics of psychiatry in the 1960s and 1970s (Szasz, 2007, p. 183):

> The widespread acceptance and use of the so-called tranquilizing drugs constitutes one of the most noteworthy events in the recent history of psychiatry. [...] These drugs, in essence, function as chemical straitjackets. [...] When patients had to be restrained by the use of force
> -for example, by a straitjacket- it was difficult for those in charge of their care to convince themselves that they were acting altogether on behalf of the patient. [...] Restraint by chemical means does not make [the psychiatrist] feel guilty; herein lies the danger to the patient (Szasz, 1957a, p. 91).[86]

(86) "The widespread acceptance and use of so-called tranquilizing drugs constitutes one of the most remarkable developments in the recent history of psychiatry. [...] These drugs function, in essence, as chemical straitjackets. [...] When patients have to be forcibly subjected to (by

For Szasz it is absurd, from a logical point of view, to expect drugs to solve the very problems of human life that psychiatrists call mental illnesses (Szasz, 1960a, p. 115). Both historically and today, psychopharmacology does not represent a new revolutionary method of treating alleged illnesses but "a new political way of controlling people and unwanted behaviors by chemical means" (Szasz, 2007, p. 175), in short, "a new excuse for exercising psychiatric coercion" (Szasz, 1987, pp. 164-165).

As I will show in the fourth chapter, many trials are published today that demonstrate the stratagems used by the pharmaceutical industry to create false psychiatric illnesses of "undoubtedly" organic origin for which they already have the chemical "remedy". It is easy, then, to blame pharmaceuticals for the inflation of pharmacological treatments (Cf. Frances, 2014). However, Szasz considers that those primarily responsible for this are the psychiatrists themselves who diagnose the "diseases" and prescribe the drugs:

> True, the drug companies mislead the public, but they could not do this if psychiatrists did not engage in the manufacture of madness by manufacturing psychiatric diagnoses, equating them with brain diseases, and writing prescriptions for psychiatric drugs. Long before drug companies profited from the creation of new mental illnesses, psychiatrists were busy creating

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It is difficult for the caregivers to convince themselves that they are acting strictly in the patient's best interest. [...] Subjugation by chemical means allows [the psychiatrist] not to feel guilty; therein lies the danger for the patient."

mental illnesses, such as drapetomania, nymphomania, masturbatory insanity, and homosexuality (Szasz, 2007, p. 184).[87].

Szasz does not oppose the administration of drugs voluntarily but their use against the patient's wishes using the psychiatric alibi of proceeding in his good, since his "biological condition" (the mental illness) prevents him from acting as a moral agent. What would happen, Szasz asks, if after receiving such treatment the patient still refuses to be "helped" - would this be proof that he rightly rejects the treatment or, on the contrary, that the treatment was ineffective and must be re-administered against the patient's will (Szasz, 1996, p. 95)? (Szasz, 1996, p. 95). This dilemma shows again that, in the absence of objective evidence, the decision on the diagnosis and, in this case, the pharmacological treatment is a matter that depends exclusively on the subjective interpretation of the psychiatrist, which puts in a serious epistemological predicament both the biologicist conception of mental illness and the scientific-medical status of psychiatry that derives from it.

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[87] "It is true that pharmaceutical companies deceive the public. But they would not have been able to do so if psychiatrists had not been involved in manufacturing psychiatric diagnoses (making them equivalent to brain diseases) or prescribing psychiatric drugs. Long before pharmaceutical companies profited from the creation of new mental illnesses, psychiatrists were busy creating such illnesses as drapetomania, nymphomania, masturbatory insanity, and homosexuality."

2.2. SZASZ, LIBERAL POLITICIAN AND ABOLITIONIST OF PSYCHIATRY

2.2.1. SZASZ'S RADICAL LIBERALISM

In the second statement of his "Manifesto," Szasz argues that "like church and state, psychiatry and the state should be separated by a 'wall'" (Szasz, 1998). He defines as a classical liberal, an advocate of the ethics of individualism and opposed to "the coercive force that family, environment, society or justice can impose on an individual" (Szombati, 1981).

> There are things the state can't do and shouldn't try to do. I refer to the libertarian principle that the state shouldn't do what the people can do for themselves. The state can't protect people beyond a certain, very minimal, point. [...] I am not an anarchist. [...] I consider anarchism unrealistic. [...] But I believe with traditional libertarians that the state should do as little as possible in competition with individual initiative. The state should provide for national defense and exercise the police function and some types of regulatory functions. But the more the state does beyond those things, the more it becomes an enemy of the people (Szasz, 1977, pp. 155, [...] 160).[88]

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(88) "There are things that the State cannot do or should not pretend to do. I refer to the liberal principle that the State should not do what people can do for themselves. The State should not protect people beyond a certain point. [I am not an anarchist. [...] I consider anarchism utopian. [...] But I believe, with the classical liberals, that the State should do as little as possible to compete with individual initiative. The State should take care of national defense and exercise the police function and some other regulatory functions. But the more the State does outside these domains, the more it will become the enemy of the people" (Trad.: 1980, pp. 225, [...] 232).

The state should not protect people from themselves or meddle in their affairs. It should leave them alone unless they infringe on the life, liberty or property of others. However, Szasz laments that, instead, "we are moving toward a form of totalitarian system [what he calls Therapeutic State (1968) or Pharmacracy (2001)] which everybody minds everybody else's business and nobody minds their own" (Mitchell, 2009). He considers non-voluntary psychiatry, specifically forced hospitalization, to be a political act, a resource employed by the state against dissenting citizens:

> I have been interested in involuntary mental hospitalization not only because it is such a blatant violation of human rights, but also because it reveals so clearly how we have medicalized certain moral and political problems. If someone wants to do something we really don't like-such as killing himself-then we say he is depressed and lock him up in a mental hospital. How is that possible? Because psychiatry says that depression is a disease; obviously, if you are an American, you should want to live. Look how similar that is to people's being locked up in mental hospitals in the Soviet Union because they criticize the system. Obviously, to the Soviet state and its psychiatrists, anyone who publicly expresses political dissent must be crazy; if he weren't crazy, he would be an obedient Communist. [...] All involuntary psychiatry is political. It's the use of the police power of the state against the dissenting citizen. It is as simple as that (Szasz, 1977, p. 147)[89]

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(89) "I have been interested in non-voluntary psychiatric hospitalization not only because it constitutes a flagrant violation of human rights, but also because it reveals very clearly how we have medicalized certain moral and political problems. If someone wants to do something we really don't like (like killing himself), we say he is depressed and lock him up in a psychiatric hospital. How is this possible? Because psychiatry says that depression is a disease. Obviously, according to it, if you are an American, you should want to live. Note that this is the same thing that happens in the Soviet Union where they lock up in psychiatric hospitals those who criticize the system. Obviously, for the Soviet system and its

In the third statement of his "Manifesto," Szasz vindicates the presumption of competence of the individual, particularly the so-called mentally ill, before the courts of law as a morally responsible agent of his or her actions: "Individuals charged with criminal, civil, or interpersonal offenses should never be treated as incompetent based solely on the opinion of mental health experts" (Szasz, 1998). However, this is what happens when psychiatrists declare a person judicially incompetent and not responsible for his or her conduct because of an alleged mental illness. , so-called mentally ill adults are treated as if they were children and their claims are not considered since it is assumed that they do not know what they are saying or what is good for them (Szasz, 1956b, pp. 304-305 and 1960d, pp. 404). The fact that the request of a patient who wishes to be discharged from a hospital is denied is evidence of the conflict of interests between him as a free citizen and the medical and judicial authorities as agents of the state (Szasz, 1960b, p. 221). Another example of such a conflict is the compulsory psychiatric evaluations of a defendant:

> It may be objected that mind tapping,[90]as against wire tapping, is intended for the defendant's benefit, and hence, in the final analysis, is not injurious to his "best interests." Let us see if this is so. [...] What happens if the defendant refuses to submit to pre-trial psychiatric examination? [...] In the face of this dilemma, the courts and legal scholars have held, first,

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psychiatrists, anyone who publicly expresses his political disagreement must be crazy because, if he were not, he would be an obedient communist. [...] All non-voluntary psychiatry is fundamentally political. It is the use of the police power of the state against the dissenting citizen. As simple as that" (Trad.: 1980, p. 215- 216).

[90]Szasz uses the term "mind tapping" in analogy to "tapping" to refer to psychiatric evaluations performed on a defendant prior to trial to determine his or her mental state.

> that a person's unwillingness to participate in a psychiatric interview is itself *prima facie* evidence of mental illness (Szasz 1962a, p. 324-325).[91].

In this case, the person is considered incapable of appearing in court and is committed to a psychiatric hospital for an indefinite period of time. According to Szasz, the lack of judicial protection for those suspected of mental illness is an attack on the rights and dignity of the person:

> It is evident that a person accused of "mental illness" and threatened with the possibility of incarceration in a mental hospital [...] does not possess these elementary legal safeguards. In these respects, therefore, he lacks the guarantees of *personal freedom* which all democratic societies have considered essential for insuring the dignity of man (1960d, p. 402).[92].

In the 1960s, Szasz published occasional liberal articles on social issues such as abortion rights and homosexuality: "The Ethics of Birth Control - Or: Who Owns Your Body?" (1960e); "Who Has a Right to an Abortion?"
(1962c); "Legal and Moral Aspects of Homosexuality" (1965b); "The Ethics of Abortion".

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(91) "It may be objected that psychiatric eavesdropping, unlike wiretapping, is intended to benefit the defendant and , ultimately, is not detrimental to his 'best interests'. Let us see if this is so. [...] What happens if the defendant refuses to submit to the pretrial psychiatric examination? [...] Faced with this dilemma, courts and law professors have established, first, that a person's reluctance to participate in psychiatric interviews is itself *prima facie* evidence of mental illness."

(92) "It is evident that a person accused of 'mental illness' and threatened with the possibility of being incarcerated in a psychiatric hospital [...] does not possess basic legal safeguards. In this sense, , he lacks the guarantees of *personal liberty* that all democratic societies have considered essential to ensure the dignity of the human being."

(1966). However, since the early 1970s, he focused on two issues (not counting those of the critique of coercive psychiatry) that he considers paradigmatic of the, in his opinion, undue intervention of the state in private matters: drug use and the

suicide. His first articles on the subject were "The Ethics of Suicide" 1971a) and "The

Ethics of Addiction" (1971b) followed by many other articles and four books: *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers* (1974b); *Our Right to Drugs: The Case for a Free Market* (1992); *Fatal Freedom: The Ethics and Politics of Suicide* (1999); and his last book, *Suicide Prohibition: The Shame of Medicine (*1999).

(2011). Generally, he published these articles on social issues in non-specialized journals.

He became an active disseminator of his liberal ideas not only through these articles but also in his frequent interventions in the press, radio and television. Below I will briefly present the theses defended by Szasz on each of these topics.

On the question of suicide, Szasz considers that life belongs only to the individual. However, physicians, particularly psychiatrists, systematically violate the freedom of the individual to dispose of his life and to decide how to end it. The argument used by psychiatrists to coerce the suicidal person is that the latter, being deranged, does not know what he is doing. On the contrary, Szasz claims that the suicidal person is doing nothing more than exercising his freedom:

> I maintain that each person belongs primarily to him- or herself and that he or she is the sole master of his or her life and death. Of course, a suicide attempt, or a successful suicide, greatly disturbs the victim's environment. However, I would like to rejette in a categorical way the conclusions of some of my confreres according to whom anyone who wants to commit suicide is a person.

and for whom this mental illness justifies a psychiatric hospitalization or forced treatment.

It is well understood that I can only approve the idea of providing psychotherapeutic help in cases of suicidal intentions. But on the express condition that the person concerned desires this help. Par contre, je m'élève contre [...] qu'un parent serait autorisé à provoquer une intervention psychiatrique forcée, prétendument pour "sauver" les gens d'eux-mêmes. Most often, doctors and psychiatrists refuse to limit their help to voluntary measures. And for good reason! With such assistance, the person can not only gain the will to live, but also the strength to die (Szombati, 1981).[93]

In a television interview,[94]the journalist asks him what he would do if he saw a person considering jumping out of a window. Would he ask the police to set up a net? Szasz answers in the affirmative, but only to protect passers-by. The journalist insists: let's imagine that there is no one on the , should a net be set up? Szasz's answer

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(93) "I maintain that any person belongs, in the first place, to himself and that he is the sole master of his life and his death. Certainly, a suicide attempt or a completed suicide greatly disturbs the victim's environment. But I categorically reject the conclusions of some my colleagues that anyone who wants to commit suicide is a disturbed person and that his or her mental illness justifies psychiatric hospitalization or forced treatment.

Let it be clear that I can only approve of the idea of providing psychotherapeutic help in cases of suicide attempts, but on the express condition that the person concerned desires such help. On the contrary, I rebel against [...] [the fact that] a relative is authorized to promote a forced psychiatric intervention, supposedly to 'save' people from themselves. Most of the time, physicians and psychiatrists refuse to limit their assistance to voluntary measures. And rightly so! By such assistance, the person may not only gain the will to live but also the strength to die."

[94]For the well-known program "Firing Line" directed by William F. Buckley. It was recorded on May 16, 1973 and broadcast on television on July 15 of the same year.

Szasz is: No. The journalist says that doesn't sound very nice, to which Szasz replies that he is not there to be nice but to "be clear about an extremely important issue that affects, after all, our whole society" (Szasz, 1973, p. 16). The "theme" is classic Szasz: unconditional respect for people's freedom of choice as long as it does not harm others.

Regarding drug use, Szasz considers that people addicted to drugs are addicted to them voluntarily. It is a habit that no one has forced them into, so they alone are responsible for their use and they alone must assume the personal or legal consequences derived from such activity. On the other hand, he argues that there is a whole mythology about the chemical dependence caused by drugs that lacks rational basis and that disregards the desire of the person to use them punctually or to become dependent on them (Szasz, 1974a, p. 4). In the television interview referred to above Szasz states the following:

> My point is that all chemical substances, drugs, should be free available in a free country. [...] You can drive cars in such a way that you wreck them. You can use high buildings in such a way that you jump out of them. And certainly you can use alcohol, cigarettes, opiates in such way that you poison yourself with it.
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> Now, in my opinion, the right to poison oneself is an absolute and qualified right in a free society. It's not desirable. I'm talking about the proper, self-disciplined use of these drugs, especially opiates and cocaine. Now amphetamines also -after all, amphetamines have been on the market for a long time and they are- Well, I'm not recommending any of these drugs. I think that one is much better off without drugs (Szasz, 1973, p. 4).[95]

(95) "My position is that, in a free country, all chemicals (drugs) should be freely available. You can drive cars to wreck them. You can also use tall buildings to jump off them. And, of course, you can use alcohol, cigarettes, opiates to poison yourself with them.

Szasz advocates open and rigorous education about the effects of each drug and defends a free market for drugs and medicines (Szasz, 1974a, p. 5). This would limit the doctors' monopoly on their prescription, which he considers a form of social control. They should act as mere informers, leaving ultimate decision and responsibility for the use of drugs and medicines to the people (Wyatt, 2004, pp. 76-77).

2.2.2. FOR THE ABOLITION OF COERCIVE PSYCHIATRY

In the fourth and fifth statements of his manifesto, Szasz advocates the abolition of involuntary psychiatric hospitalization: "no person should be involuntarily detained other than for the purpose of punishment or in an institution other than one formally defined as part of the criminal justice system of the state"; and of the insanity defense: "to exempt a person from responsibility for a criminal act on the basis of his inability to form a conscious purpose is an act of mercy masquerading as an act of medical science" (Szasz, 1998).

The forensic psychiatrist is supposed to be an expert in human affairs who assists a court of law in finding the truth by scientific methods. However, Szasz claims that a public place where a person is to stand trial and where the psychiatrist is under pressure to establish, in a limited time, the truth about facts not

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Even if it is not desirable, poisoning oneself is, in my opinion, an absolute right and proper to free societies. [But I do not recommend the use of any of these drugs. I believe that one lives much better without them".

physical but subjective, is not the most suitable to achieve such objectives, indeed, it is materially impossible (Szasz, 1956b, pp. 307-308). On the contrary, the real function of the forensic psychiatrist in a judicial context is to act as a social tranquilizer who advises, arbitrarily but forcefully, the court which must decide the person's fate (Szasz, 1958a, p. 195). Mental illness is the justification on which the above is based (Szasz, 1960c, pp. 561-562): "In testifying, psychiatrists [...] resort [...] to the use of the meaningless, or, at the very least, extremely polyvalent, notion of 'mental illness' and deceive themselves into believing that, in so doing, they have issued a [medical] diagnosis when, in fact, they are simply acting as a sanctioning social instance" (Szasz, 1958a, p. 189).

> The subject matter of psychiatry is neither minds nor diseases, but lies -the "patient's" and the "psychiatrist's." These lies begin with the names of the participants in the transaction-the designation of one party as "patient" even though he is not ill, and of the other party as "therapist" even though he is not treating any illness; they continue with the lies that comprise the subject matter of the discipline-the psychiatric "diagnoses," "prognoses," and treatments." and they end with the lies that, like shadows, follow the ex-mental patients through the rest of their lives-the records of denigrations called "depression," "schizophrenia," and what not, and of the imprisonments called "hospitalization." Accordingly, if we wished to give psychiatry an honest name, we should call it
> "mendacitology -the study of lies (Szasz, 1974a, p. 8).[96]

(96) "The object of psychiatry is neither minds nor illnesses, but lies (those of the 'patient' and those of the 'psychiatrist'). These lies begin with the names of the participants in the transaction: the designation of one party as 'patient' even though he is not ill, and of the other party as 'therapist' even though he treats no illness. They continue with the lies of which the discipline is composed: psychiatric 'diagnosis', 'prognosis' and 'treatments'. And they end with the lies that, like shadows, haunt ex-mental patients for the rest of their lives: the written record of the denigrations of their patients.

The social function of psychiatry, exemplified by its performance in the courts, is twofold: on the one hand, to remove from society people considered undesirable and, on the other hand, to protect people from themselves (since they supposedly do not know what they are doing). In both cases, psychiatrists can recommend to the judge a condemnatory sentence, involuntary hospitalization, without the alleged "sick" person having committed any crime or, on the contrary, a sentence of acquittal, mitigating or exempting from punishment, due to mental derangement, even though the person has actually committed a crime. Thus, the psychiatrist's testimony before a court, based on his subjective interpretation, can lead either to the conviction of an innocent person to be committed to a psychiatric hospital (*civil commitment*) and to receive involuntary treatment or to the exoneration of a criminal claiming an absence of criminal responsibility due to mental illness (*insanity defense*). Psychiatrists "incarcerate people and, if not, coerce them into doing things they do not want to do such as being committed or receiving electroshocks, and/or provide excuses for people who have done something wrong and have legal or personal problems" (Mitchell, 2009).

Institutional psychiatry cannot pretend to evade the dilemma of serving two masters at the same time, the patient and society (Szasz, 1960b, p. 220). This contradiction is usually resolved in favor of society and against the patient: "My thesis is that, in committing a patient to a psychiatric hospital, the essential role of the physician is that of 'agent of the community'" (Szasz, 1957b, pp. 297). Thus, "hitherto, in psychiatric matters, this dilemma has been resolved (perhaps somewhat unthinkingly) in favor of the

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called 'depression,' 'schizophrenia,' and, of course, of incarcerations called 'hospitalization'. Accordingly, if we were to give psychiatry an appropriate name we would call it 'mendaciology,' the study of lies."

'treatment' and human dignity and the protection inherent in 'fair trial'" (Szasz, 1960d, pp. 410-411).

In a trial, the "patient" is completely unarmed before the authority of the psychiatrist. If the psychiatrist diagnoses him as mentally ill, he cannot prove that he is not. This does not happen when it comes to any other illness or any crime: based on contrasted evidence, it is proved or ruled out that such a person has such an illness or has committed such a crime (Mitchell, 2009). The person accused of being insane (which is not a crime) cannot defend himself on equal terms with the prosecution, reminiscent of the argument in Kafka's *The Trial* (Szasz, 1960b, p. 223):

> Once the psychiatrist has made a "diagnosis," the patient is considered "sick." The psychiatrist does not have to prove his allegation (in court or outside of it). But the patient must now prove, as it were, that he is "not sick." And how can he do this, especially when he is ignorant of the criteria used to establish that he was "sick" in the first place? Thus, in sum, the patient has no counter-diagnostician (comparable to the defense attorney), the judge is not impartial, and the patient finds himself in legal jeopardy without having broken a law or being accused of a crime, and without having been tried and convicted (Szasz, 1960d, pp. 407- 408).[97].

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(97) "Once the psychiatrist has made a 'diagnosis', the patient is considered 'ill'. The psychiatrist does not have to prove his allegation (either in court or out of court). But the patient must prove, say, that he is 'not sick'. And how can he do that, especially when, from the outset, he is ignorant of the criteria that were used to determine that he was 'sick'? So, in short, the patient has no counter-diagnostician (comparable to a defense attorney), the jury is not impartial, and the patient is at legal risk without having broken any law or been charged with a crime, and without having been tried and convicted."

Just as it cannot be proven by medical-scientific standards that a person suffers from a so-called mental illness, the affected person cannot prove that he or she does not. Therefore, the psychiatrist's testimony, based not on objective facts but on subjective beliefs and interpretations, has a disproportionate weight in judicial decisions. Everything depends on the psychiatrist's personal judgment.

Szasz is against both involuntary psychiatric hospitalization and treatment and the legal defense of insanity. As in the case of slavery, he does not consider that involuntary psychiatry should be reformed (as other critics of psychiatry have proposed) but abolished (Szasz, 1981a, pp. 399 and 403). To defend and make his position more understandable, he proposes to translate psychiatric terminology into common language. Thus, a "hospital" in which one is committed against one's wishes and from which one cannot leave at will is a prison (Szasz, 1958a, p. 196). Similarly, the psychiatrists who run such prisons ("psychiatric hospitals") and who keep the prisoner ("mentally ill") do not act as doctors but as jailers: "a person who locks someone up is a jailer, even if he has a medical degree and wears a white coat" (Szasz, 1981a, p. 400). Thus, psychiatric confinement cannot be understood, as is usually done, as a measure of care or cure but "*as a form of social control* [sanction] *employed against certain persons* [the insane] *who violate certain rules* [expected modes of behavior]" (Szasz, 1957b, pp. 298, italics in original). The great psychiatric pantomime consists in making society see that such a thing is done according to scientific standards and for the good of the individual when, in reality, it is done with a political and moral criterion for the good of the people, as is the case with criminals: "Although the fact that such confinement occurs against the patient's wishes is obvious, this is usually ignored or minimized. On the contrary, the assertion of

that hospitalization is for the ultimate benefit of the patient is generally emphasized" (*Op.cit.*, pp. 293-294).

Moreover, the treatments practiced in psychiatric hospitals (such as electroshocks, lobotomies or the administration of psychotropic drugs) were advertised as scientifically proven discoveries to combat mental illness. Such treatments, carried out in the name of medical science but against the patient's will, far from proving their efficacy, constitute a real crime against the victim who suffers them and "a barbarism unworthy of medicine" (Szombati 1981).

> Criminals are deprived of their liberty, and it is openly admitted that this is not for arrangement might not be quite as good for their benefit but for that of society. [...] We say, therefore, that they are in "jail". Furthermore, such confinement can only be inflicted *after* the violation of a law. Commitment, on the other hand, pertains to a situation in which persons are deprived of their liberty allegedly for their own benefit. Society is thus forced into the semantic trick of asserting that such people *are* in "hospital" (not in "jail") and are there, moreover, for "treatment" (not "punishment"). May I suggest that we consider the similarities between this modern approach to "mental illness", on the one hand, and the spirit under-lying the medieval Crusades, on the other? The latter, as we know, were characterized by certain social actions-by one group against reduplicating the first stage in this scheme.
>
> Another -in such a way that those who wielded force claimed to have done so for the benefit of their partners. Clearly, this is of great help for the inner sense of right of those who feel impelled to *act*. By the same token, to call state hospitals "hospitals"-rather than "jails"- serves only, or mostly, to make society feel better. [...]
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> Consider further the violence of the "treatments", such as insulin and electric shock, lobotomy and now the new chemical" straight-jackets", and the fact that so many of the patients *do not*

feel and *think* that all this is of any help to them. Could it possibly be that all this is really not designed or expected to help them? (Szasz, 1957b, p. 304).[98]

Regarding the legal defense of insanity, Szasz states that "by excusing someone and claiming that he does not know what he is doing (i.e., that he is 'insane'), we 'help' the person at the price of sacrificing his human dignity and his right of self-assertion" (Szasz, 1960c, p. 565).

In short, he considers that involuntary commitment and the insanity defense are the two paradigmatic social functions of institutional psychiatry and that, as long as these practices remain in force, it will be impossible to abolish them (Sullum, 2000). He proposes that psychiatrists should abandon their social functions, which have nothing to do with scientific criteria, but

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(98) "It is widely admitted that criminals are deprived of their liberty not for their own benefit but for the benefit of society. [...] We say, thus, that they are in 'prison'. Such confinement can only be applied after the violation of a law. Psychiatric confinement, on the other hand, refers to a circumstance whereby people are deprived of their liberty supposedly for their own benefit. Thus, society is deceived by the semantic trap that claims that such people are in a 'hospital' (not a 'prison') to be 'treated' (not 'punished'). Might I be permitted to suggest that we consider the similarities between, on the one hand, this modern approach to 'mental illness' and, on the other, the spirit that fueled the medieval crusades? The latter, as we know, were characterized by certain social actions (by one group against another) that those in power claimed to carry out for the benefit of their fellow citizens. Clearly, this aids the inner sense of well doing of those who feel impelled to *act*. Similarly, calling state hospitals 'hospitals' (and not 'prisons') serves only, or mainly, to make society feel better. [...] Consider, moreover, the violence of 'treatments' such as insulin or electric shock, lobotomy and, today, the new chemical 'straitjackets', and the fact that many of the patients do not feel, or believe, that all this helps them at all. Could it be possible that all this, in fact, was not designed or arranged to help them?"

Finally, they should assume the capabilities and limitations of their practice and dedicate themselves to what they should be doing: helping people who voluntarily seek their services.

> This social difference between physical and mental diseases finds its clearest expression in the phenomenon of the legal commitment of the insane to mental hospitals. By committing someone to a mental hospital, psychiatrists act in the role of one of society's agents, whose duty it is to protect society from certain types of nuisances. This function is discharged under the guise of providing "treatment" for the "mentally ill." While it has been generally assumed that commitment of the mentally ill should rightly be a "psychiatric function," it might be worthwhile to reexamine this assumption. Perhaps it would be better, socially as well as psychotherapeutically, if psychiatrists would limit themselves to functions which require the special technical skills which they possess, and would forego participation in activities which result in the disenfranchisement of people (Szasz, 1958a, p. 196).[99]

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(99) "The social difference between physical and mental illness finds its clearest expression in the phenomenon of the legal internment of the insane in psychiatric hospitals. By committing someone to a psychiatric hospital, psychiatrists represent the role of agents of society, whose task is to protect it from certain nuisances. This function is fulfilled under the guise of offering 'treatment' to the 'mentally ill'. Although it has generally been accepted that the institutionalization of the mentally ill would be, properly speaking, a 'psychiatric function', it would be worthwhile to re-examine this assertion. Perhaps it would be more appropriate, both socially and psychotherapeutically, for psychiatrists to limit themselves to functions that require the special technical skills they possess and to refrain from engaging in activities aimed at people."

2.3. SZASZ, BEHAVIORAL AND PSYCHOANALYTIC THEORIST

2.3.1. HUMAN BEHAVIOR ACCORDING TO SZASZ

In the second book of *The Myth of Mental Illness*, entitled *Foundations of a Theory of Personal Conduct*, Szasz presents a novel way of understanding human behavior based on the epistemological premises presented in the first book of this work that I have discussed above. In *Foundations of a Theory of Personal Conduct*, Szasz proposes to abandon the traditional medical-psychopathological thinking about "mental illness" and to consider human behavior as the result of a set of psycho-social factors in which the subject's desire is involved.

Szasz considers that mental illnesses are more akin to languages (intentional communication through signs) than to organic illnesses. Therefore, it is not useful to focus on the etiology of an alleged illness, as physicians would do, but to understand the language of illness as learned communicational behavior and the context in which it is used, more in the manner of philosophers, linguists and sociologists (Szasz 1961b, pp. 11-12; Transl.: 1999, pp. 54-55). Szasz does not consider mental illness as the consequence of biological factors but as a type of behavior expressing certain subjective choices conditioned mainly by the social context. Thus, any behavior should be seen as the result of a personal, though not always conscious, choice on the part of the individual that results in a particular combination of using linguistic signs, following social rules and participating in existential games. In support of his thesis, Szasz draws on the theories of other authors from different fields of the human sciences, such as, in philosophy, logic

Hans Reichenbach's symbolic theory (*Elements of symbolic logic*), Bertrand Russell's theory of denotation (*Human knowledge*), Susanne Langer's symbolic theory (*Philosophy in a new key*), Anatol Rapoport's operationalism (*Operational philosophy*) and Percy W. Bridgman (*The way things are*) and Richard S. Peters' theory of motivation (*The* concept of motivation); in psychoanalysis, Ronald Fairbairn's object relations theory (*Psychoanalytical studies of personality*) and Harry S. Peters' interpersonal psychoanalysis (*The concept of motivation)*. Peters (*The concept of motivation*); in psychoanalysis, the object relations theory of Ronald Fairbairn (*Psychoanalytical studies of personality*) and the interpersonal psychoanalysis of Harry S. Sullivan (*The interpersonal theory of psychiatry*); in sociology, the social behaviorism of George H. Mead (Mind, self, and personality). Mead (*Mind, self, and society*) and Erving Goffman's symbolic interactionism (*The presentation of self in everyday life*); and, in psychology, Jean Piaget's theory of cognitive development (*Judgement ans reasoning in the child*). All of this is framed, as in every work by Szasz, in classical liberal political theory, whose author most referred to in this text is Herbert Spencer (*The man versus the state*).

In the Introduction to *The Myth of Mental Illness. Foundations of a Theory of Personal Conduct*, Szasz insists, for sake of psychiatric science, on "the need to be clear" (*Op.cit.*, p. 3; trans.: 1999, p. 42). He states that not recognizing the origins, methods and proper function of psychiatry and, on the contrary, imitating medicine out of an unexplained desire to participate in the social recognition enjoyed by physicians, seriously jeopardizes its meaning, its usefulness and even its very existence (*Op.cit.*, p. 4; Trans.: 1999, p. 43).

A science can be defined in terms of nouns and entities, i.e., by what researchers say they study (theories); or in terms of processes, i.e., by the concrete activities researchers carry out and the methods they employ (practices). Sciences such as physics or chemistry complement both aspects with rigor, being constantly exposed to refutation. Psychiatry, on the hand, is defined solely by

by its substantive conceptualizations (the study of mental illness) and avoids defining itself clearly by its methods, which, contrary to what it claims, makes it a pseudoscience (*Op.cit.*, pp. 1-2; Transl.: 1999, pp. 39-40). Szasz considers that if psychiatry is to be considered a serious science it must be defined by its actual operations and not merely by its idealistic theories.

A psychiatrist can do many things of many different kinds using many different methodologies: administering drugs, applying electroshocks, forcibly committing patients, testifying in court, and so on. But what Szasz is interested in investigating here is the psychiatrist's facet as a specialist in psychotherapy, "whose method consists 'only in talking', as it is often said with a touch of mockery but quite appropriately" (*Op.cit.*, p. 3; Trans.: 1999, p. 41). The basic function of psychiatrists is to listen, analyze and talk, that is, to interact and communicate with the patient, which connects psychiatry with disciplines such as semiotics or sociology and distances it from the natural sciences. However, when talking about their work, psychiatrists express themselves as if they were physicians, biologists or even physicists. In terms of the object of study and intervention and the methods used in psychotherapy, psychiatry has much more in common with the social and human sciences than with the natural sciences, but psychiatrists disavow the former by pretending to act as physicians (*Op.cit.*, p. 3; Transl.: 1999, p. 42).

Szasz defends the recognition of psychiatry as a social science that basically deals with the analysis of communicational interactions and not as a medical science whose "cultural scaffolding rests instead on physical and chemical principles. [...] It does not seem possible that the behavior of sign use lends itself to be explored and understood in these terms" (*Op.cit.*, p. 3; Transl.: 1999, p. 42).

On this conceptual and epistemological basis, Szasz expounds his theory of human behavior in the second book of *The Myth of Mental Illness*, where he proposes, first of all, a semiotic analysis (and not a medical one, as official psychiatry prefers) of mental illness. For this, he will take hysteria as a paradigm of mental illness.

For Szasz, hysterical symptoms are a proto-language that is expressed through the body and that takes two factors as referents: the physical illness that is always expressed through symptoms and sensations; and the cultural custom of caring for the sick. This proto-language has three pragmatic functions: an informative use that "consists in communicating and, therefore, in convincing the receiver (of the message) that the patient is incapacitated" (*Op.cit.*, p. 127; Transl.: 1999, p. 210); an affective use through which the sender intends to "deliberately arouse certain emotions in the listener, thereby inducing him to respond with certain actions" (*Op.cit.*, p. 129; Transl.: 1999, p. 212); and a promotive use by means of which the sender seeks to make the receiver perform certain acts, generally using the imperative mode: ¡cuídame!, ¡ayúdame! (*Op.cit.*, p. 132; Transl.: 1999, p. 216). Hysteria is not a disease but a personal use of the language of the disease, either through ignorance of the one who uses it (he does not know any other language), or to try to obtain a benefit (attention, care, etc.), or for a combination of both motives (*Op.cit.*, p. 12; p. 55).

Along with this classification of the language of disease according to its logical and semantic complexity, Szasz points out another way of classification according to its degree of symbolism. There is, on the one hand, discursive or cognitive language whose function is to inform (e.g. scientific language) and, on the other hand, non-discursive language whose function is to express emotions, feelings or desires (e.g. body language) (*Op.cit.*, pp. 133-134; Transl.: 1999, pp. 217-

218). Hysterical bodily signs belong to the latter category, although they do not fail to transmit certain cognitive information: "In the symbolism of his symptom the patient presents [...] the whole history and structure of his 'neurosis' [...]. To understand 'symptom' we must know all the historically singular characteristics of the social circumstances and the development of his personality" (Op.cit., p. 136; trans.: 1999, p. 221). However, it is not possible to fully express a sensation, an emotion or a psychic symptom in a discursive language (*Op.cit.*, p. 138; Trans.: 1999, p. 224) (Cf. Berrios, 2011).

The conclusion of this semiotic analysis of the behavioral form called hysteria and its pseudo-symptoms is that, far from being a real disease, it is a non-discursive proto-language, a very basic form of communication in semantic and symbolic terms whose function is to behaviorally imitate a real disease: "A hysterical attack is the iconic sign of an authentic (organic) epileptic seizure. [The bodily signs [...] are an integral part [...] [of] the language of the disease" (*Op.cit.*, p. 117; Transl.: 1999, p. 196).

Secondly, Szasz considers that the behavior called "mental illness" follows certain socially established rules of behavior: that of the helplessness of children and their care by parents and those of the Judeo-Christian religions that encourage human beings to behave "in a childish, stupid and irresponsible manner" (*Op. cit.*, p. 13; Transl.: 1999, p. 57). Szasz questions the ethic of helplessness and considers any tendency to infantilism as a strategy to bypass the rules of the adult game of life that entails an autonomous and responsible attitude (*Op. cit.*, pp. 183-187; Trans.: 1999, pp. 286-290).

Finally, Szasz proposes an explanation of human behavior in terms of play. He establishes a hierarchy of games: lower level or object games (e.g. organic diseases) and higher level or meta-games (e.g. "mental illness"). The former concern physical survival and the latter concern the way of living (*Op.cit.*, p. 14; Trans.: 1999, p. 58): "once the person rises above the level where the simplest type of object game (that of survival) is played, it is inevitable that he must face ethical choices" (*Op.cit.*, p. 15; Trans.: 1999, p. 59).

For Szasz, games are paradigmatic examples of social relations. Human beings are characterized, unlike animals, by their ability to abide by rules, adopt roles and participate in games. Hysteria, far from being a disease, is an infantile mode of participation in a game based on egocentrism, imitation (personification or adoption of social roles) and heteronomy, different from the adult mode of participation in the social game based on cooperation, rational observance of rules and personal autonomy (*Op.cit.*, pp. 223-226; Transl.: 1999, pp. 343-347).

The function of the psychotherapist is to "unravel the game of life in which the patient participates" (*Op.cit.*, p. 14; Transl.: 1999, p. 58), for which the meaning of proto-language must first be revealed and the person must be helped to learn a symbolically more sophisticated metalanguage: "The basic objective of psychoanalytic treatment is to enable the patient to learn to know his object relations and his communicational behavior. The passage from proto-language to object language and metalanguage must be successfully accomplished before attempting to master the much more transcendent task of self-knowledge" (*Op.cit.*, p. 301; Trans.: 1999, p. 451).

Szasz warns the clinician of the risks of interpreting psychic symptoms, specifically psychosomatic symptoms, displayed by the patient literally rather than symbolically, since there is a substantial difference between events (something that happens to the person without his or her subjective intervention, as would be an organic disease or an accident) and actions (occurrences in which the person's desire, albeit unconsciously, is engaged). This has repercussions in therapy, since "interpreting behavior as an occurrence implies taking it for its apparent value and considering it as a 'real thing'. Conversely, behavior interpreted as action implies treating it as a sign and seeing it as representing or carrying some other thing (a message or 'meaning')" (*Op.cit.*, p. 171; Transl.: 1999, p. 269).

In short, the ultimate goal of Szasz's exposition of human behavior and its psychotherapeutic treatment is to establish a clear boundary between the concepts, objects and methods of medicine and those of psychotherapy: physicians are natural scientists working with things and psychotherapists are social scientists working with symbolic behaviors. Therefore, in relation to the non-discursive language of hysteria and its psychotherapeutic approach, "whenever a communication expressed in the language of iconic bodily signs is interpreted (i.e., translated) into the cognitive scientific language of medicine, misinformation is sure to result" (*Op.cit.*, p. 141; Transl.: 1999, p. 228).

2.3.2. THE ETHICS OF PSYCHOANALYSIS ACCORDING TO SZASZ

"The whole problem of psychiatry lies in the question of whether the person is undergoing treatment voluntarily or against his will" (Szombati, 1981). In the sixth and final statement of his "Manifesto," Szasz advocates a private, contractual psychiatry (psychotherapy) as an alternative to coercive institutional psychiatry: "We seek to replace involuntary psychiatry (psychiatric slavery) with contractual relationships between professionals and their clients" (Szasz, 1998).

He considers that there are two antagonistic psychiatries: that which is exercised with the patient's consent, where the psychiatrist is the agent of the individual; and that which is exercised against the patient's will, where the psychiatrist acts as an agent of society. He points out that psychiatrists never make such a distinction as they maintain that they always try to help the patient and accuse anyone who questions this of unprofessionalism (Szasz, 1981a, p. 397). The therapeutic relationship must be private, confidential and contractual (Sullum, 2000) only in this way can the psychotherapist be the exclusive agent of the patient and not of society (Szasz, 1960c, pp. 561; Wyatt, 2004, p. 80).

For Szasz, the patient is the only one responsible for his or her life and, therefore, the only one who can change his or her behavior. The psychotherapist only acts as a catalyst (Sullum, 2000). His role is not to cure the patient of an alleged illness but to help him to solve, by himself, his existential problems through dialogue, discourse analysis and personal counseling (Sullum, 2000). Psychotherapy is thus a matter of ethics rather than technique (Wyatt, 2004, p. 81).

These views held by Szasz throughout his life are the concretization, in clinical practice, of his epistemological premises, his liberal ideals and his theory of human behavior which he presented in *The Myth of Mental Illness* and in a score of articles on psychoanalysis and psychotherapy written in the late 1950s and early 1960s culminating, in 1965, with the publication of *The Ethics of Psychoanalysis*. *The Theory and Method of Autonomous Psychotherapy*,[100]a work in which he laid out the theoretical and methodological foundations of the kind of psychoanalysis he advocated: "Formulating the analytic enterprise in terms of communications, obeying rules, and playing games, enables us to describe the process of analysis differently, and I believe more accurately" (Szasz, 1965a, p. 201; Trans.: 1971, p. 238). "The analyst's task is to translate [...] the language of excuses into the language of responsibility. A large part of the daily work of analysis consists in making this kind of translation to the patient and teaching him to do it himself" (*Op.cit.*, p. 193; Trans.: 1971, p. 230).

The Ethics of Psychoanalysis is structured in three parts, entitled: "The Scientific Study of Psychotherapy", "The Theory of Autonomous Psychotherapy", and "The Method of Autonomous Psychotherapy". In this section I will focus on the first two, dedicated to the theoretical foundations of autonomous psychotherapy, leaving the third part, of a methodological nature, for future research. As in the case of *The Myth of Mentall Illness*, here I do not intend to present a complete summary of what Szasz said in *The Ethics of Psychoanalysis*, nor to make a critical analysis of it. I will only state the fundamental ethical principles on which Szasz bases his psychotherapeutic method.

[100]I take as reference the first edition of this book published in 1965 by Basic Books. The translation into Spanish that I am including here is the one made by Santos Sánchez Salor in 1971 for the publishing house Gredos. I will quote together the original reference and that of the translation.

Szasz devotes this work to analyzing the different functions of the psychotherapist and to defending the positions that, in his opinion, he should adopt before his patient. Specifically, it is the answer to a dilemma he posed in an earlier article (Szasz, 1964), in which he questions the different positions that a psychotherapist can adopt in his work. The fundamental decision facing the psychotherapist, says Szasz, is whether he will act as an agent of the individual or of the group, or, in political terms, whether he will advocate individualism or collectivism, or, in ethical terms, whether his attitude will promote autonomy or heteronomy in his patient (Szasz, 1964, pp. 527). A firm advocate of the liberal ethics of individualism, Szasz decided to call his psychotherapeutic method, not without certain reservations, "autonomous psychotherapy":

> For many years, I have wrestled with the problem of what to call the sort of psychotherapy I practice [...]. There are two alternatives. On the one hand, I could refer to it simply as "psychoanalysis," because I think that it *is* psychoanalysis. Perhaps Freud and the early Freudians would have agreed. Our aim is the same: to extend the control of the ego over certain areas of the id, as they put it, or to augment the client's capacity for self-determination and making choices, as I prefer to put it. Our methods, too, have much in common; [...] the therapist's sole task is to "analyze." Hence, were I to give a new name to the therapeutic method I shall describe, I would risk being criticized for using a new word to describe psychoanalysis and thus claiming as mine what in fact belongs to Freud.
>
> [...] Now everyone uses the word "psychoanalysis" to mean whatever he pleases. Thus, were to assert that the therapy described in this book is psychoanalysis, many analysts would probably repudiate the claim. Psychoanalysis, they might counter, is what they practice, not what I do. Since there is no recognized method for arbitrating such a dispute, who is to say what should be called psychoanalysis and what should not?
>
> The second alternative is to call my way of practicing psycho by a new name. [...] "Autonomous psychotherapy." I chose this expression to indicate the paramount aim of this

procedure: preservation and expansion of the client's autonomy. To emphasize the nature of therapeutic method, rather than its aim, the procedure could also be called "contractual psychotherapy"; the analyst-analysand relationship is determined neither by the patient's "therapeutic needs" nor by the analyst's "therapeutic ambition," but rather by explicit and mutually accepted set of promises and expectations, which I call "the contract."

The main advantage of giving a new name to the therapy described is that it would separate it from the many other psychotherapeutic enterprises now called psychoanalysis. If interpretations of behavior, interlaced with the administration of psychic tranquilizers and energizers, is a form of psychoanalysis; if the therapy of psychotic patients, involuntarily hospitalized is also a form of psychoanalysis; and if the so-called training analysis, characterized by the analyst's active and coercive control of the life of the analysand, is still another form of psychoanalysis -then autonomous psychotherapy is *not* psychoanalysis and ought to be distinguished from it.

The main disadvantage [...] is the one already mentioned: to many it will seem a renaming of what is "really" psychoanalysis. In addition, a new name for a psychotherapeutic procedure tends to imply some radical novelty of method and a promise of exuberant curative powers. But there are no such implications in this case, nor do I make such claims.

I have decided to solve this problem by adopting the following plan: I shall use the terms "psychoanalysis" (or "psychoanalytic treatment") and "autonomous psychotherapy" interchangeably and synonymously. This usage [...] will leave the psychotherapist and social scientist free to decide whether my method needs a new label. [...] It seems especially appropriate, therefore, that a book on autonomous psychotherapy should leave the reader free to decide whether the author's ideas and methods differ sufficiently from those of his colleagues to justify the use of a new name (Szasz, 1965a, pp. 6-8) [101] [102][101] [102]

[101]In this thesis I will not respond to the challenges proposed by Szasz as to what is the true nature of psychoanalysis and whether the therapeutics he advocates deserve a new name. This would entail a thorough review of Freud's theories and those of the different psychoanalytic schools (Adlerian, Jungian, interpersonal, etc.),

orthodox, Kleinian, object relations, Lacanian, etc.) and compare them with Szasz's theses, which would merit an independent investigation with different objectives from those pursued here.

(102) "For many years I have struggled with the problem of what to call the kind of psychotherapy I practice. [...] There are two alternatives. On the one hand, I can refer to it simply as 'psychoanalysis,' because I believe it *is* psychoanalysis. Perhaps Freud and the early Freudians would approve. Our goal is the same: to extend the control of the *self* over certain areas of the *id*,(*)as they say, or to increase the client's capacity for self-determination and decision-making, as I prefer to say. Our methods also have much in common, [...] the therapist's only task is to 'analyze'. [...] Therefore, if I were to give a new name to the therapeutic method I am about to describe, I would run the risk of being criticized for using a new word to designate psychoanalysis, thus claiming as my own what in fact belongs to Freud.

[...] Now everyone uses the word 'psychoanalysis' to mean whatever he likes. Thus, if I were to claim that the therapeutics described in this book are psychoanalysis, many analysts would probably repudiate my claim. They would object that psychoanalysis is what they practice, not what I do. There being no admitted method to arbitrate this dispute, who is to say what should be called psychoanalysis and what should not?

[The second alternative is to call my method of practicing psychotherapy by a new name. [...] 'Autonomous psychotherapy'. I choose this expression to indicate the main purpose of this procedure: the preservation and promotion of the client's autonomy. If one wants to emphasize the nature of the therapeutic method, rather than its end, this procedure could also be called 'contractual psychotherapy'; the analyst-analyte relationship is determined neither by the 'therapeutic needs' of the patient nor by the 'therapeutic ambition' of the analyst, but rather by a series of promises and expectations that I call 'the contract'.

[...] The main advantage of giving a new name to the therapeutics described here is that it would be separated from the many therapeutic enterprises now called 'psychoanalysis'. If behavioral interpretations, interwoven with the administration of tranquilizers and psychic tonics, are a form of psychoanalysis; if the therapeutics of psychotic patients, hospitalized against their will, is also a form of psychoanalysis; and if so-called didactic analysis, characterized by active and coercive control over the life of the analysand, is another form of psychoanalysis; then autonomous psychotherapy is *not* psychoanalysis and must be distinguished from it.

Szasz coined the term "autonomous psychotherapy" in a 1962 article, "Human Nature and Psychotherapy: A Further Contribution to the Theory of Autonomous Psychotherapy", in which he presents the type of psychotherapy he considers appropriate to realize the ideal of what he calls the "moral person" (Szasz, 1962b, p. 268). For Szasz, people are moral beings if they possess the capacity and freedom to make decisions. In *The Moral Criterion in the Child*, Jean Piaget described freedom of decision as characteristic of the autonomous personality in contrast to the heteronomous personality that is governed by externally imposed norms of conduct. As Erich Fromm put it in *The Fear of Freedom*, to direct oneself autonomously in life increases the moral stature of the person (*Op.cit.*, p. 271). Autonomous psychotherapy, as a variant of psychoanalysis, is Szasz's proposal to help the person who wishes to approach this ideal, which presupposes, in the first place, that the psychotherapist conducts himself autonomously following the ethics of individualism.

The main drawback [...] is the one already mentioned: to many it will seem like a renaming of what psychoanalysis 'really' is. Moreover, in giving a new name to a psychotherapeutic procedure, one tends to assume some radical novelty in the method and a promise of exuberant curative powers. But, in this case, there is no such novelty, nor do I claim it.

I have decided to solve this problem by adopting the following plan: I will use the terms 'psychoanalysis' (or 'psychoanalytic treatment') and 'autonomous psychotherapy' alternatively and synonymously. This usage [...] will leave the psychotherapist and the social scientist free to decide whether my method needs a new name. [...] It seems quite appropriate that a book on autonomous psychotherapy should leave the reader free to decide whether the author's ideas and methods differ sufficiently from those of his colleagues to justify the use of a new name" (1971, pp. 21-23).

(*)Note: In 1932, Freud said that the purpose of psychoanalysis is "to strengthen the *ego*, to make it more independent of the *super-ego*, to enlarge its field of perception and develop its organization, so that it can appropriate new parts of the *it*. Where it was *it*, it must be *I* [*Wo Es war soll Ich werden*]" (Freud, 1974, p. 3146). This statement has been interpreted differently by different psychoanalytic schools.

The kind of psychotherapy I usually practice might most aptly be called "autonomous psychotherapy". Previously, I described it as the adaptation of psychoanalytic character analysis to the values of autonomy and freedom in human relations. This means that the therapist must refrain from all measures which limit the patient's freedom of action or expression, both inside and outside the therapeutic situation. [...] Interference with the patient's extra-analytic life is incompatible with this technique. The relationship must, of course, be absolutely confidential. Certain ideas about the nature of man underlie this mode of working. Perhaps the chief one is the notion that man has the ability to make choices and decisions; and that the processes of choosing and deciding are facilitated by self-reflection, or better, by critical inspection of the socio-historical field in which he lives. The notion that man is, or should be, free to make decisions, especially those decisions mainly affecting his own life, is implicit in the technical requirements of autonomous psychotherapy. The patient may be assisted in his quest for making the right decisions -that is "right" for him, not someone else- by information about himself and his behavior (*Op.cit.*, p. 277).[103]

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(103) "It would be accurate to call the kind of psychotherapy I usually practice 'autonomous psychotherapy'.

Earlier I described it as the adaptation of psychoanalytic character analysis to the values of autonomy and freedom in human relationships. This means that the therapist must refrain from making any indication that limits freedom of action or expression in the patient both outside and inside the therapeutic situation. [...] Interfering in the extra-analytic life of the patient is incompatible with this technique. Of course, the relationship must be absolutely confidential. Certain ideas about the nature of the human being this way of working. Perhaps, the main one is that the person possesses the capacity to make choices and decisions; and that the processes of choosing and deciding are favored by introspection or, better, by the critical examination of the socio-historical context in which he/she lives. The idea that human beings are, or should be, free to make decisions, especially those that affect their lives to a greater extent, is implicit in the technical requirements of autonomous psychotherapy. The patient could be counseled in his search for the right decisions (i.e., 'right' for himself, not for anyone else) by means of knowledge of himself and his behavioral forms" (Szasz, 1962b, p. 277).

According to Szasz, these are the same ethical principles that were originally followed by psychoanalysis: "Freud devised a method of psychotherapy to broaden the autonomy of the patient and called it 'psychoanalysis'" (Szasz, 1965a, p. VIII; trans. 1971, p. 11). To achieve this goal, the psychoanalyst must renounce the benefactor ethic of the physician who, following a scientific methodology, *gives* and *does* something concrete to the patient: "The physician's task requires him to deal with the physical and the causal, and to treat the patient, at least in part, as an object. The psychiatrist's job requires him to deal with the psychological and existential, and to treat the client as a person. The psychotherapist does nothing to the patient and employs no method *on* him" (*Op.cit.*, p. 37-38; Transl.: 1971, p. 58). However, psychiatrists and psychotherapists routinely claim that they act as physicians and scientists because "when we call something 'scientific,' we mean that it is accurate, effective, good, honest, rational, or trustworthy [...]. One can only hope that psychoanalysts [psychiatrists, psychologists, psychotherapists, etc.] pretend to be scientific [...] because, if their work were qualified as unscientific (or unscientific), it would be charged with a negative value" (*Op.cit.*, p. 32; Transl.: 1971, p. 52). For Szasz, the first obligation of a scientist is to be honest with the real foundations of his science, which, as already mentioned, in the case of psychiatry, have nothing to do with medicine but with the social sciences. Szasz does not conceive psychoanalysis as a medical practice but as a high form of moral education (meta-education) (cf. Szasz, 1963).

> I propose to describe psychotherapy as social action, not as healing. So conceived, psychoanalytic treatment is characterized by its aim -to increase the patient's knowledge of himself and others and hence his freedom of choice in the conduct of his life; by its method
> -the analysis of communications, rules and games; and, lastly, by its social context- a contractual, rather than a "therapeutic," relationship between analyst and analysand. In sum, I shall attempt to define the nature of psychoanalysis; clarify its limits; and establish its proper

relations to other forms of psychotherapy, medicine, ethics, and social science (Szasz, 1965a, pp. VIII-IX).[104]

Szasz proposes to recover the subversive character that psychoanalysis had in its early days and which was later frustrated with the institutionalization and medicalization of the discipline: "psychoanalysis began as a 'subversive' social enterprise and (...) it must remain so if it is to remain faithful to its historical and intellectual mandate. Its mission was, and still is, to 'demystify' personal and social fictions" (*Op.cit.*, pp. 60-61; Transl.: 1971, p. 83).

> It is fruitless to approach the problems with which psychoanalysis deals and the solutions it offers for them primarily from the point of view of medicine or traditional psychiatry. Psychoanalysis belongs to the history of ideas and to the history of man's relation to his fellow man. [...] I believe that the main intellectual and scientific value of psychoanalytic treatment lies [...] in the kind of model the analytic relationship provides for achieving a better understanding of ethics, politics, and social relations generally. So far as I know, no one has ever suggested this (*Op.cit.*, pp. 12-13).[105]

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(104) "I propose to describe psychotherapy as a social action, not as a cure. Thus conceived, psychoanalytic treatment is characterized by its purpose: to increase the patient's knowledge of himself and of others, and thus his freedom of choice in the conduct of his life; by its method (the analysis of communications, rules and games); and, finally, by its social context (a relationship between analyst and analysand, contractual rather than therapeutic). In short, I shall attempt to define the nature of psychoanalysis, to clarify its limits, and to establish its just relations with other forms of psychotherapy, medicine, ethics and social science" (1971, p. 11).

105 It is useless to approach the problems dealt with by psychoanalysis and the solutions it offers for them primarily from the point of view of medicine or traditional psychiatry. Psychoanalysis belongs to the history of ideas and to the history of the relationship of human beings with their fellow human beings [...]. I believe that the main

He criticizes other types of materialistic therapies, such as those based on organicism, which, under the premise that the mind is the brain, commits itself "morally and philosophically to consider human beings as machines and, consequently, to treat people as things" (*Op.cit.*, p. 30; Trans.: 1971, p. 49); or in behaviorism which, unlike psychoanalysis, does not consider behavior as an expression of the subjectivity of the individual as a but "as fragmented piece of behavior, separate and alien to the identity of the actor" (*Op.cit.*, p. 39; Trans.: 1971, p. 59). On the methodological level, Szasz criticizes the use of all kinds of apparatus and devices in psychotherapy in order to appear scientific and defends the need for a truly honest approach that recognizes that the only "special skill of the psychotherapist lies in his expertise in directing his relationship with patients" (*Op.cit.*, p. 32; Trans.: 1971, p. 51).

Psychoanalysis, unlike other therapies, aims at fostering the patient's autonomy or "freedom to develop oneself, to increase one's knowledge, to perfect one's aptitudes, and to acquire responsibility for one's behavior. Freedom to direct one's own life, to choose between different courses of action as long as it is not detrimental to others" (*Op.cit.*, p. 22; Transl.: 1971, pp. 39-40). This obliges the psychotherapist to renounce the classic hierarchical doctor-patient relationship and engage, on the contrary, in a relationship based on a contract between equals. He criticizes psychoanalysts who maintain a medical relationship with their patients:

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scientific and intellectual value of psychoanalysis consists [...] in the kind of model that the analytic relationship facilitates for acquiring a better understanding of ethics, politics and social relations in general. To my knowledge, no one has suggested this to date" (Transl.: 1971, p. 28-29).

> The medical situation -of which the analytic situation has traditionally been considered a subspecies- is usually a replica of the family situation. As the parent cares for the child, so the doctor cares for the patient. [...] If the relationship between analyst and patient is like that between father and child, then, by definition, it is inimical to aim of analysis. How can the analyst help his client become autonomous and free in the conduct of his own life if the relationship between them is based on status, with the patient cast in the inferior rank, and, further, if the analyst subjects the patient to a heteronomous influence, based on authority and command? (*Op.cit.*, p. 112).[106].

In short, autonomous psychotherapy requires the psychotherapist to follow ethical principles different from those traditionally followed by physicians and copied by many psychotherapists: "Freud realized long ago that the psychoanalyst should not have too vehement a desire to 'cure'" (*Op.cit.*, p. 45; trans. 1971, p. 66).

> What distinguishes this enterprise [autonomous psychotherapy] from others is that, although the analyst tries to help his client, he does not "take care of him." The patient takes care of himself. Furthermore, the analysand realizes that he is "expected to recover," [...] in a purely moral sense, by learning more about himself and by assuming greater responsibility for his conduct. He learns that only self-knowledge and responsible commitment and action can set the stage for his own recovery.

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(106) "The medical situation (of which the analytic relationship has traditionally been considered a subspecies) is ordinarily a replica of the family situation. Just as the parent cares for the child, so the physician cares for the patient [...] If the relationship between analyst and patient is like that between parent and child, then, by definition, it is hostile to the purposes of psychoanalysis. How can the analyst help his client to behave autonomously and freely in his life, if the relationship between them is based on a hierarchy, with the patient situated in the lower grade, and if, in addition, the analyst subjects the patient to a heteronomous influence based on authority and command?" (Trad.: 1971, p. 140).

him free. In sum, autonomous psychotherapy is an actual small-scale demonstration of the nature and feasibility of the ethic of autonomy in human relationships (*Op.cit.*, p. 24).[107].

Szasz ends *The Ethics of Psychoanalysis* by offering a series of advice to the young psychotherapist. I consider that the one that best sums up the spirit of this work is the last one: "You are responsible for your own behavior, not for that of the patient. This is the central principle of autonomous psychotherapy" (*Op.cit.*, p. 220; Transl.: 1971, p. 260).

(107) "What distinguishes this relationship [that of autonomous psychotherapy] from others is that, even when the analyst tries to remedy his patient, he does not 'take care of him'. The patient takes care of himself. Moreover, the analysand realizes that he is 'expected to recover' [...] in a purely moral sense, learning more about himself and accepting greater responsibility for his behavior. He learns that only self-knowledge and responsible commitment and action can set him free. In short, autonomous psychotherapy is a real demonstration, on a small scale, of the nature and possibility of the ethics of autonomy in human relationships" (Transl.: 1971, p. 42).

PART TWO THOMAS

S. SZASZ AND

THE CRITICS OF PSYCHIATRY

3. SZASZ, THE ANTIPSYCHIATRY AND POSTPSYCHIATRY

As shown above, Szasz uses his conceptual and epistemological analysis of "mental illness" as a basis for launching a frontal attack on institutional psychiatry and its coercive practices. His aim is none other than to abolish them. For this reason, Szasz was always seen, rather than as a philosopher, as a radical politician, which earned him, to his chagrin, the appellations of "anti-psychiatrist" or "father of anti-psychiatry", qualifications that, as I will indicate in this chapter, he never ceased to reject and fight against.

Despite his extensive work and worldwide fame, Thomas Szasz does not often appear in manuals on the history of psychiatry and psychoanalysis[108] and, in the few in which he is mentioned, it is briefly and as the founder of the anti-psychiatry movement:

> As a part of the reaction to the [psycho]analytic dissection of culture, a movement arose in the 1950's, known as antipsychiatry, which held that all of conventional psychiatry should be scrapped because the trouble essentially lay with a society that was in itself schizophrenic. The leaders in this movement were the British psychiatrist R.D. Laing and David Cooper; along somewhat different lines, Thomas Szasz in the United States made equally caustic comments about conventional psychiatry (Fine, 1979, p. 481).

We find another example of this in the description that the historian of psychiatry Edward Shorter gives of the anti-psychiatry movement, where he names, as its main representatives (in this order), Thomas Szasz, Erving Goffman, Michel Foucault, Franco

[108]See, for example, Schwartz (1999), Mitchell and Black (2004), or Makari (2012).

Basaglia, Ronald Laing and David Cooper (Shorter, 2005, pp. 22-26). For his part, the historian Roy Porter also names Szasz, Goffman, Basaglia and Laing as leading anti-psychiatrists (in that order) (Porter, 2002, pp. 209-210).

The same occurs in texts on the philosophy of psychiatry or critical psychiatry. In almost none of them Szasz is referred to[109]and if he appears in any of them it is, once again, as an anti-psychiatrist: "During the 1960s and 1970s it was dissident psychiatrists such as Thomas Szasz and Ronald Laing who formed the core of what became known as the anti-psychiatry movement" (Bentall, 2011, p. 38).

Szasz always denied being an anti-psychiatrist and launched harsh criticisms against such a concept and against the founders of the movement (Szasz, 1984a, 2003, 2003, 2004, 2004, 2008b and c, 2009, 2010 and 2012), taking pains to clearly mark the boundary between his own positions and theirs: "I am against involuntary psychiatry [...] but I am not against [...] psychiatric relations between consenting adults. [...] The very term anti-psychiatry implicitly forces one to oppose everything psychiatrists do, which is obviously absurd" (Szasz, 1984a, p. 50).

Disassociating himself from the anti-psychiatry movement was one of Szasz's great concerns, especially in his last years. Thus, he devoted his penultimate book (which he published at the of 89) to declaring his rejection of anti-psychiatry perhaps with the desperate intention of convincing us that he did not deserve to go down in history as an anti-psychiatrist: "In 1967[110], my

[109]See, for example, Luque and Villagrán (2000), Álvarez, (2012), or Berrios (2011).

[110]This date refers to publication of Cooper's book *Psychiatry and Antipsychiatry* in which this term appeared. However, Szasz reports that: "The term antipsychiatry [...] was used

efforts to undermine the moral legitimacy of the alliance of psychiatry and the state suffered a serious blow: the creation of the anti-psychiatry movement" (Szasz, 2009, p. VIII). "*My writings are neither part of psychiatry nor of anti-psychiatry*. They belong to conceptual analysis, socio-political criticism and common sense. This is why I rejected, and continue to reject with equal force, psychiatry and anti-psychiatry" (*Op.cit.*, p. X).

As I will show in this chapter, Szasz despises antipsychiatry not only for its particular theories and practices but, mainly, for what he considers its main imposture: antipsychiatrists claim to defend some principles but act in the opposite way. Specifically, says Szasz, anti-psychiatry postulates the non-existence of mental illness and, at the same time, proposes an alternative treatment for patients. Szasz believes that, if there is no illness, there can be no medical treatment, no matter how alternative it may be. In this sense, he states that anti-psychiatry is just the other side of the coin that he shares with traditional psychiatry. That is why he will oppose "with equal force" both. If Szasz was so clear in his criticism of anti-psychiatry, why is he still considered an anti-psychiatrist, and does he deserve such a label? In this chapter I will try to answer these questions. To do so, it is useful to first make a brief historical analysis of the anti-psychiatry movement and a summary of the positions of its supposed representatives in order to distinguish who were really its supporters and who were not.

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from 1912 by Bernhard Beyer to characterize a critical article on psychiatry. [...] *Die Bestrebungen zur Reform des Irrenwessen*" (Szasz, 1984a, p. 76).

3.1. HISTORY OF ANTIPSYCHIATRY

3.1.1. WHAT WAS ANTI-PSYCHIATRY?

It is not my intention to analyze antipsychiatry in depth or to criticize its foundations. I only intend to outline what different authors have written on the subject in order to clarify where antipsychiatry begins and ends. The chained reading the following quotations will allow the reader to obtain a summarized but clear idea of what anti-psychiatry was. It should be noted that in all the texts from which I extract these quotations (a small but significant representation of the many existing ones) Szasz is always named as an antipsychiatrist, along with Laing, Cooper, Basaglia, Goffman or Foucault.

> Early in the 1960s, as part of the general intellectual tumult of the time, a protest movement arose against psychiatry (Shorter, 2005, p. 22).

> Its tenets were varied and controversial [...]. What was common to anti-psychiatry, however, was the critique of the asylum (Porter, 2002, pp. 209-210).

> Antipsychiatry was a social movement that questioned not only the legal privilege of psychiatrists to detain and treat individuals with mental disorders, especially in a compulsory manner, but also the increasing "medicalization" of madness. Finally, antipsychiatry questioned the very existence of mental illness itself (Berlim, Fleck and Shorter, 2003, p. 61).

> The anti-psychiatric movement grew in the realm of politics, particularly the politics of the left, which was considered [...] the only instrument against capitalist oppression. It gained its

initial respect and glamour from its association with the prevailing existential philosophy at the time (Nasser, 1995, p.743).

Anti-psychiatry must be understood as a contributing element in the history of new social movements generally. [It was an event in the history of British political culture (Crossley, 1998, p. 888).

Anti-psychiatrists [...] received wide publicity throughout the era and enjoyed a popularity in the growing culture of left wing politics in 1950's and 60's Britain. Anti-psychiatry was brought into the social sphere by its supporters, transforming it far from just a collection of similar theories and criticisms into a cultural phenomenon, and its key figures became the spokespeople of a new movement. [Anti-psychiatry's themes about society and freedom resonated with the political climate of the time. They found an increasing readership among the emerging new left crowd of the 1950's and '60's counter-culture scene. Indeed, much of anti-psychiatry was influenced by the same counter-culture enthusiasms, for communal living, love, LSD, and the like, making a fusion of values inevitable. This shift amounted to a movement against psychiatry (Ralley, 2012).

We understand by "anti-psychiatry movement" a group of psychiatrists who, at the end of the sixties, will reject a medical psychiatry, while proposing an alternative psychiatry, more social and communitarian. [...] Antipsychiatry [...] obtains a great resonance at a time of generalized criticism of authority and repression (we are within the current of May '68), because psychiatric confinement is the paradigm of a coarse repression legitimized by psychiatric "knowledge-power". [...] It will be after May '68, and through countercultural criticism, that this question will come to the forefront of public opinion, thus going beyond professional and university circles, and psychiatric repression will now be criticized both from within (anti-psychiatric movement) and from outside (anti-psychiatric movement).

from outside (new social movements of the sixties) (Pastor and Ovejero, 2009, p. 296- 299).

> Antipsychiatry in retrospect may be seen as an ideological movement based on a politicized and reductionistic understanding of psychiatry. [...] The *Zeitgeist* of the 1960s and 1970s, epitomized by the rebellion against the "system", helps explain not only why antipsychiatrists were so influential at the time but also why they were slowly forgotten afterwards (Berlim, Fleck and Shorter, 2003, p. 66).

From these quotes it can be concluded that the anti-psychiatric movement was born in England in the 1960s as part of the countercultural and anti-system movements of the time. It was a left-wing social, political and cultural movement, anti-capitalist and inspired by existential philosophy, which questioned the validity of the concept of mental illness and fought against the madhouse, coercive treatments and, in , the *medicalization* of madness typical of traditional psychiatry. As an alternative to hospitalization, the anti-psychiatrists proposed a community-based approach to madness and, as an alternative to involuntary treatment, advocated the vindication and promotion of the free expression of the authenticity of madness. The contextualization of the anti-psychiatric movement within the framework of the countercultural manifestations of the 1960s explains both its rise and its demise. Let us now see if these premises are equally fulfilled by the authors who are considered anti-psychiatrists: Foucault, Goffman, Laing, Cooper, Basaglia and Szasz.

3.1.2. WHO WERE THE ANTI-PSYCHIATRISTS (AND WHO WERE NOT)?

Far from being close, Laing, Foucault, Goffman and Szasz did not know each other when they published their first books in the early 1960s, nor did they quote each other in them.[111]If they coincided in their criticisms, it was due to the growing social indignation about the psychiatric tortures practiced at that time (involuntary internment and bloody "therapeutic" practices), which led to the questioning of the scientific foundations and the social function of psychiatry. Coincidentally, within a few months the four titles were published which, according to the general criterion, form the intellectual core inspiring what was later called, in England, the anti-psychiatric movement. I do not intend to analyze these or other works by these authors (except, obviously, those of Szasz) but only to mention their main arguments for purely documentary purposes. Nevertheless, I consider that a comparative analysis of these four fundamental writings would be a project as novel as it is necessary. Unfortunately, such an initiative is beyond the scope of the present research devoted exclusively to Thomas Szasz.

In 1960, the Scottish psychiatrist Ronald Laing published in Great Britain *The Divided Self* (Laing, 1993). In this work Laing seeks, through the exposition of cases and from a phenomenological-existential perspective, "to make madness and the [individual] process of becoming mad understandable" (*Op.cit.*, p. 9). This novel way of understanding madness revolves around what Laing called an existential position of "primary ontological insecurity" (*Op.cit.*, p. 35) characteristic of schizophrenia:

[111]Except Goffman and Szasz, who coincided, presumably, in Chicago and Bethesda (Cf. Goffman, 1994) and who were cited in the books referenced here (Goffman, 1994 and Szasz, 1961b).

> The individual, in the ordinary circumstances of living, may feel more unreal than real; in a literal sense, more dead than alive, precariously differentiated from the rest of the world, that his identity and autonomy are always in question. It may lack the experience of its own temporal continuity. It may lack a countervailing sense of personal congruence and cohesion. He may feel more insubstantial than substantial, and unable to suppose that the stuff he is made of is genuine, good, valuable. And he may feel that his self is partially divorced from his body (*Op.cit.*, p. 38).

In 1961, the philosopher Michel Foucault published in France *History of Madness in the Classical Age* (Foucault, 1976),[112]a work in which he carried out a historical analysis of madness and asylum institutions. Foucault considers that madness and normality are not natural entities but social constructs and that the internment of the insane in asylums is a subtle political maneuver of subjugation endorsed by a pseudo-scientific knowledge, psychopathology, constituted as truth:

[112]Enric J. Novella reports that, before *History of Madness in the Classical Age*, "as is known, Foucault completed in the early fifties a theoretical and practical training as a psychologist, and even considered the possibility of studying medicine in order to devote himself to psychiatry. As a result of this experience and his early theoretical concerns, the young philosopher published a series of works - including two chapters for collective works ('Psychology from 1850 to 1950' and 'Scientific Research and Psychology', both published in 1957), an introductory book for a popular collection (*Mental Illness and Personality*, 1954) and an extensive foreword to the French translation of L. Binswanger's essay The Dream and the *Personality*, 1954). Binswanger *The Dream and Existence* (also originally published in 1954) - in which he already dealt intensively with the problems of psychiatry and psychology" (Novella, 2008, p. 5).

> The psychopathology of the nineteenth century (and perhaps still ours) believes to be situated and to take its measures in relation to a *homo natura*, or to a normal person given prior to any experience of illness. In fact, this normal human being is a creation; and if he is to be situated, it is not in a natural space, but in a system that identifies the *socius* of the subject of law; and as a consequence, the madman is not recognized as such because an illness has thrown him the margins of normality, but because our culture has placed him at the meeting point between the social decree of internment and the juridical knowledge that discerns the capacity of the subjects of law. The "positive" science of mental illness and those humanitarian sentiments that have elevated the madman to the rank of human being have only been possible once this synthesis, which forms, in a certain sense, the concrete *a priori* of all our psychopathology with scientific pretensions, has been solidly established (Foucault, 1976, pp. 207-208).

As we already know, in 1961 the professor of psychiatry Thomas Szasz published in the United States *The Myth of Mental Illness*, an essay in which he questions the conceptual and epistemological foundations of psychiatry as a so-called medical science: "A psychiatrist [is] a psychiatrist insofar as he claims to be oriented toward the problem of mental health and illness. But let us imagine for a moment that this problem does not exist" (Szasz, 1961b, p. 2; Transl., 1999, p. 40). Starting from this hypothesis, Szasz sets out to "demolish some of the false substantive principles of contemporary psychiatric thought" (*Ibid.*).

In 1961, the Canadian sociologist Erving Goffman, who two years earlier had written his well-known work *The Presentation of the Person in Everyday Life* (Goffman, 1981), published *Boarding Schools (*Goffman, 1994). This book is devoted to the study of what he calls "total institutions" (specifically, psychiatric hospitals) and, specifically, to

analyze the situation of the institutionalized patient. This sociological study coincides both with Szasz's criticism of the coercive practices of institutional psychiatry and with the Foucauldian analysis of psychiatric power.

> The professional psychiatric staff does not have an easy role. The medical licensure of its members gives them one of the firmest titles to the deference and regard of our , and one of the strongest occupations of skilled service, and yet in the psychiatric hospital their role is constantly in question. They must legitimize everything that happens there, assimilating it, or translating it to fit the frame of reference of the medical service. The daily actions of the staff must be defined and presented as expressions of observation, diagnosis and treatment. To effect this translation, reality must be distorted considerably, as it is distorted by judges, instructors and officials in another of our coercive institutions. A crime must be discovered to fit the punishment, and the character of the inmate must be reconstituted to fit the crime. [...]
>
> Mental patients can find themselves in a unique predicament. If they want to get out of the hospital, or make their existence in it somewhat less harsh, they must prove that they willingly accept the position they are given there; and that position is to support the occupational role of those who, it seems, impose that condition. This self-alienating moral subservience of the self, which perhaps helps to understand the state of mental confusion into which some inmates sink, is fulfilled in the name of the illustrious tradition of professional reparation services, and especially of their medical variety. Mental patients may find themselves crushed by the weight of an ideal of service, which makes life easier for the rest of us (*Op.cit.*, p. 376-378).

These four essays form a magnificent forerunner of what would later be called critical psychiatry (see the fourth chapter of this thesis), which will study the historical and political origins of psychiatry and will question the foundations of psychiatry.

epistemological practices of this discipline as well as its practices oriented from a biomedical model. Together, these four works constitute a complete critical frame of reference oriented from the humanities: history (Foucault), epistemology (Szasz), psychology (Laing) and sociology (Goffman).[113]Let us now see what path these four authors followed after the publication of these important books.

Foucault did not return to deal directly with the history of psychiatry until 1973, when he devoted his seminar at the *Collège de France* to *Psychiatric Power* (Foucault, 2005), in which he revised and corrected some aspects of what he had presented in *History of Madness*. Foucault never undertook a political advocacy for the rights of inmates in insane asylums as he did for those of inmates in ordinary prisons. Goffman published,

[113]Also at the same time that these four works were published, other important books were published whose authors question the relationship of submission of the individual to authority and the question of moral responsibility for personal decisions. For example, in 1961 was published the correspondence between the philosopher Günther Anders and Major Claude Eatherly (Eatherly and Anders, 1962), who participated in the bombing of Hiroshima and whom psychiatrists preferred to label as insane rather than consider that his response to the massacre (feeling of guilt and awareness of personal responsibility) could be morally adequate. The self-incrimination of Eatherly, an army officer, pointed subsidiarily to the US State as the guilty party. He had to be silenced, and it was the psychiatrists, as agents of the State, who took charge of this. In 1961, the trial of Adolf Eichmann was held, who wanted to justify his crimes with the argument of due obedience, recounted by Hannah Arendt in her well-known book *Eichmann in Jerusalem* (Arendt, 2003). Inspired by this trial, that same year, the psychologist Stanley Milgram began his famous experiment on obedience to authority, which was published two years later (Milgram, 1963) (also interesting are the "conformity experiments" that Solomon Asch, Milgram's teacher, conducted ten years earlier and in which he showed how a pressure group can persuade a subject to accept a clearly wrong opinion, which is consistent with Szasz's thesis on the myth of mental illness).

in 1963, *Stigma* (Goffman, 1993), where he presented a sociological analysis of the labeling process[114]suffered by marginalized groups, among them, the so-called mentally ill. As already mentioned, in 1970 he founded, together with Thomas Szasz and the jurist George Alexander, *The American Association for the Abolition of Involuntary Mental Hospitalization* (AAAIMH). Goffman continued his sociological studies within the framework of symbolic interactionism. For his part, Szasz published *Law, Liberty and Psychiatry* in 1963 (Szasz, 1968) and *Psychiatric Justice* in 1965 (Szasz, 1988), works which he criticized the alliance between psychiatry and the State against the freedom of individuals and, specifically, the social function of psychiatry in relation to the law, exemplified in activities such as *civil commitment* and *insanity defense*. In the following years, Szasz published dozens of books and hundreds of articles on the philosophy of psychiatry and criticism of coercive psychiatric practices. Finally, Laing published two books in 1964: *Sanity, Insanity and the Family* (Laing and Esterson, 1980), with Aaron Esterson, in which the authors present a study on the family context and its determining role in schizophrenia[115]; and *Reason and Violence: A Decade of Thought (*Laing and Esterson, 1980); and *Reason and Violence: A Decade of Thought (*Laing and Esterson, 1980), in which the authors present a study

on the family context and its determining role in schizophrenia(115).

[114]Labeling theory was developed during the 1960s and 1970s by sociologists such as, among others, Erving Goffman, Howard Becker, Edwin Lemert and Thomas Scheff. In their work they analyze how the identity and behavior of individuals can determined or influenced by the terms used to describe or classify them. Particularly relevant to this thesis is the well-known article by psychologist David Rosenhan, "On Being Sane in Insane Places" (Rosenhan, 1973), published in the prestigious journal *Science*, where an original sociological experiment demonstrating the arbitrariness of psychiatric diagnoses is presented. Rosenhan and eight volunteers requested appointments in different psychiatric hospitals, most of them state-run. In interviews with psychiatrists, they reported hearing voices. Without further "proof," they were admitted with a diagnosis of schizophrenia. Although they stopped showing signs of psychosis from the very beginning, the volunteers remained hospitalized and treated with drugs for an average 19 days.

[115]The authors make a brief reference Szasz's *The Myth of Disease* (p. 11).

Sartrean (Laing and Cooper, 1972), with David Cooper, an essay on S*artre*'s work with a foreword by Sartre. During the rest of the 1960s, Laing continued to publish works critical of traditional psychiatry and in favor of a new way of understanding madness and of including it in the community sphere, for example, *The Politics of Experience: The Bird of Paradise* (1967) or *The Self and the Others* (1969). From then on, Laing's work took a literary, intimate and poetic turn (e.g., *Knots* (1970) or *Do you love me? (*1976)), far removed from his early essays.

The term "anti-psychiatry" was used in 1967 by David Cooper, a South African psychiatrist based in London, in his book *Psychiatry and Antipsychiatry*: "Deeper questioning has led some of us [psychiatrists] to propose conceptions and procedures which seem the total antithesis of the conventional ones, and which may indeed be regarded as an anti-psychiatry in germ" (Cooper, 1978, pp. 7-8). In this book, Cooper acknowledges his affinity with the work of Laing[116] and, pointedly, refers to Szasz's *The Myth of Mental Illness* (p. 41). On the other hand, he makes no mention of Foucault or Goffman. In *Psychiatry and Antipsychiatry* Cooper proclaims what could well be considered the main objective of antipsychiatry: the transfer of the madman from the hospital to the community.

> We have had many golden dreams about [the] ideal psychiatry, or rather anti-psychiatry in the community, but I think we have now, by a process of demystification [sic], sufficiently delineated the true nature of psychiatric insanity and sufficiently elaborated also our practical needs to take a step

[116]For example, pp. 10, 11 and 33.

forward. And a step forward means, in essence, a step out of the psychiatric hospital, into the community (*Op.cit.*, pp. 116-117).

A year later, in 1968, Cooper published another book, *The Dialectics of Liberation*,[117]in which people from different fields (among them Ronald Laing, Gregory Bateson and Herbert Marcuse) presented their criticisms of capitalist society and its revolutionary alternatives.[118]At no time was Szasz, Goffman or Foucault named. In reference to this book and the emergence of the term "anti-psychiatry," Szasz says:

> The term *"Antipsychiatrie"-coined* in 1908 by the German psychiatrist Bernhard Beyer-came into being largely in response to two novel social phenomena: the growth of insane asylums during the nineteenth century and the mounting popular fear of "false commitment," that is, the incarceration of sane persons in insane asylums. Beyer, like most psychiatrists of his generation, viewed any disapproval of psychiatry as lése-majesté and created the term

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[117]This book collects the lectures delivered at the *Dialectics of Liberation Congress*, organized by *The Institute of Phenomenological Studies*, which was held at The Roundhouse in Chalk Farme (London), between July 15 and 30, 1967. The back cover of the edition I use here states that this congress "was the unique expression of the current politics of dissent, in which existential psychiatrists, Marxist intellectuals, anarchists and political leaders met to discuss the key problems of the next decade. [...] The aim of the congress was to create genuine revolutionary consciousness by fusing ideology and action at the individual and mass levels" (Cooper (Ed.), 1970).

[118]Perhaps the book in which Cooper shows a greater revolutionary political intensity is *The Death of the Family*, published in 1970: "The culmination of that liberation only takes place totally in effective macro-political action. That is why the Revolutionary Centers of Conscientization must also become Red Bases, in which macro-political action is essentially negative and takes the form of making the bourgeois structures of power reduced to impotence by means of all possible resources" (Cooper, 1976, p. 77).

"antipsychiatry" as a label with which to stigmatize psychiatric criticism. This use of the term remained limited to Germany and fell into disuse during the First World War.

In the 1960s, a group of psychiatrists in London -led by David Cooper and Ronald D. Laing- reinvented the term *to distinguish themselves from establishment-psychiatrists and to define themselves as superior to them.* Instead of defining their use of this key term, Cooper explained [in 1967, in *Psychiatry and Antipsychiatry*]: "We have had many pipe-dreams about the ideal psychiatric, or rather anti-psychiatric, community." Who were the "we"? This question was answered a year later, in *The Dialectics of Liberation* (1968), edited by Cooper with the lead chapter by Laing. In the introduction, Cooper wrote, "The organizing group of [the 'Congress on the Dialectics of Liberation' held in London in 1967] consisted of four psychiatrists who . . . counter-label[ed] their discipline as antipsychiatry. The four were Dr. R.

D. Laing and myself, also Dr. Joseph Berke and Dr. Leon Redler" (Szasz, 2009, p. 4).[119]

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(119) "The term *"Antipsychiatrie"* (coined in 1908 by the German psychiatrist Bernhard Beyer) appeared primarily in response to two new social phenomena: the proliferation of insane asylums during the nineteenth century and the growing popular fear of 'false confinement,' that is, the incarceration of healthy people in insane asylums. Beyer, like many psychiatrists of his generation, regarded any disapproval of psychiatry as *lèse-majesté* and created the term 'anti-psychiatry' as a label with which to stigmatize psychiatric criticism. This use of the term remained limited to Germany and fell into disuse during the First World War.

In the 1960s, a group of psychiatrists (led by David Cooper and Ronald D. Laing) in London reinvented the term *to distinguish themselves from institutional psychiatrists and to define themselves as superior to them*. Instead of defining their use of this term, Cooper said [in 1967, in *Psychiatry and Antipsychiatry*]: 'We have had many golden dreams about the ideal psychiatry or, rather, about the anti-psychiatric community'. Who were the 'we'? This question was answered a year later, in *The Dialectic of Liberation* (1968), edited by Cooper and whose first chapter was written by Laing. In the introduction, Cooper wrote: 'The organizing group [of the 'Congress on the Dialectic of Liberation' held in London in 1967] consisted of four psychiatrists who [...] named their discipline after

Beyond the differences between the aforementioned authors, what is clear is that they agree in criticizing not only the theoretical principles of classical psychiatry but also the existence of asylums and psychiatric torture. Foucault proposed his historical-philosophical analysis of madness and the asylum institution; Goffman presented his sociological study of the life of inmates in asylums; and Szasz was the most explicit author in denouncing coercive psychiatric practices. However, Foucault did not propose any alternative. Neither did Goffman and Szasz, whose only political interest was the abolition of forced internment and involuntary psychiatric practices. It was Laing and Cooper, in England, who did implement some very peculiar alternatives to the institutionalization of the "mentally ill" and to the savage methods of treatment, the main examples of which were Villa 21 and Kinsgley Hall.[120]

Villa 21 was an experimental hospital unit for young schizophrenics created by Cooper in 1962 at the Shenley Hospital (Hertfordshire, north of London) in which he wanted to implement his revolutionary proposals. Villa 21 was closed in 1966 without achieving its objectives:[121]

> An experimental phase of staff withdrawal led to rubbish accumulating in the corridors and dining room tables being covered with the previous days' unwashed plates. Some staff controls were re-introduced with the threat of discharge if patients did not conform to the

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antipsychiatry. These four were Dr. R. D. Laing and myself, also Dr. Joseph Berke and Dr. Leon Redler."

(120) D.B. Double (2006) provides a good summary of the history of antipsychiatry and the ideas, works and projects of the so-called antipsychiatrists.

[121]See the text Villa 21: an experiment in antipsychiatry (Cooper, 1978, pp. 94-117).

> rules. These apparent limits to institutional change led to the conclusion that a successful unit could only be developed in the community rather than the hospital (Double, 2006, p. 20).

Kingsley Hall, located in East London, was the first of the residential homes for schizophrenics sponsored by *The Philadelphia Association*, a charitable organization founded by Laing, Cooper and others in Great Britain in 1965[122] (*Op.cit.*, p. 22). The main idea of this experiment was that the inhabitants could express their madness without limits or controls, that they could do whatever they wanted and whenever they wanted and that the traditional hierarchy between doctors and patients would disappear. It was common for "therapies" to take place under the effects of hallucinogenic substances such as LSD and it was not uncommon for therapists and patients to have sexual relations. Like Villa 21, Kingsley Hall was an expression of an era, the sixties, marked by counterculture, sexual liberation and protest against authority and capitalism: "Kingsley Hall did not intend to 'cure' but to offer a place where 'some may find long-forgotten or distorted identities' (Schatzman, 1972) [...]. After five years, Kingsley Hall was full of garbage and uninhabitable" (*Op.cit.*, pp. 22-23).

> In the English therapeutic community Kingsley Hall, where 194 individuals were housed [...], schizophrenia was conceived as an individual's journey into his or her "inner space". Accordingly, "treatment" consisted in helping the "traveler" through this "inner journey". The rising number of pregnancies and suicides, and the sexual violence and physical aggression associated with Kingsley Hall, led the British Department of Health to close it in the early 1970s, ending an experiment whose central feature was unrestricted freedom for patients and the abolition of all treatments considered conventional (Berlim, Fleck and Shorter, 2003, p. 63).

[122] *The Philadelphia Association* is still active (http://www.philadelphia-association.org.uk/).

The only supposedly "anti-psychiatric" action that had lasting success and real social repercussions was that undertaken in Italy by Franco Basaglia. Director of the Gorizia psychiatric hospital between 1961 and 1968, Basaglia believed that mental illness should not be treated in prison institutions such as the asylum. He proceeded, therefore, to release many patients to be cared for in the community. In 1968 he published his best known work, *The Denied Institution (*Basaglia, 1972), where he narrated his experience in Gorizia. Subsequently, he was director of the psychiatric hospital in Trieste and founded the left-wing political party *Psichiatria Democratica*. As a politician, Basaglia succeeded in getting passed, in 1978, the so-called Law 180 (or Basaglia law) which regulated the closure of asylums and the care of the mentally ill on an outpatient basis or, in any case, in a general hospital (Shorter, 2005, pp. 24-25).[123]

In the early 1970s, both those who signed themselves as "anti-psychiatrists" (Laing and Cooper) and those who did not but were attributed that label for their criticisms of institutional psychiatry (Foucault, Goffman, Szasz and Basaglia) strongly denied that they were "anti-psychiatrists" (Foucault, Goffman, Szasz and Basaglia).

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[123]In Spain, the correlate of this experience of deinstitutionalization was called the "Spanish psychiatric reform" which "could not be separated from the struggle against Franco's dictatorship" (Desviat, 2006, p. 12). However, it was not until ten years after Franco's death that the report of the Ministerial Commission for Psychiatric Reform was published in 1985, whose recommendations were included in the General Health Law of 1986 (see http://www.papelesdelpsicologo.es/vernumero.asp?id=278).

On June 12, 1989, the asylum of Jesus, considered the first in the world, founded by Father Jofré in 1409, was closed in Valencia. Many of its inmates were rehoused in the psychiatric hospital of Bétera (http://elpais.com/diario/1989/06/18/sociedad/614124001_850215.html). Today, this psychiatric hospital has few inmates. Today, most psychiatric patients are treated in outpatient clinics, day hospitals, social centers and the most serious cases are temporarily admitted to the psychiatric wards of general hospitals.

affiliation[124]since: "'anti-psychiatry' and 'anti-psychiatrist' quickly became terms [that] [...] discredit and dishonor the person to whom they are attributed and eliminate the need to consider the validity of their views" (Szasz, 2009, p. 5).

Perhaps this is why Laing "'undertakes a vigorous denunciation of 'anti-psychiatry' and wishes to separate himself completely from that term [...]: he is 'not an anti-psychiatrist', he is 'a physician and a psychiatrist'. Also Cooper rejected his self-identification as an anti-psychiatrist and [...] adopted the identity of a non-psychiatrist'" (Chris Oakley quoted by Szasz, 2009, pp. 6-7). For his part, Foucault stated, without much affectation, that "between Laing, Cooper, Basaglia and myself, there has been no affinity and no relationship" (Foucault, 1994e, p. 594). However, one of his biographers, Didier Eribon, points out that:

> Foucault [...] will approach the anti-psychiatric movements after 1968, sometimes bordering on them. [...] He will limit himself to accompany them at a certain distance, to encourage them at most. [...] In 1976, he had Cooper invited to the Collège de France for a series of conferences. [...] He will support the French translations of the books by Thomas Szasz[(125)] [...] and

[124]In reality, Goffman did not bother to affirm or deny his (claimed by others) belonging to antipsychiatry.

[125]Foucault mentions Szasz in several interviews between 1974 and 1976 (Foucault, 1994, a, b, c and d). In them, he criticizes his conservative liberalism but acknowledges his magnificent work as a historian and philosopher by devoting words of praise to his works *The Myth of Mental Illness* and *The Manufacture of Madness* (Foucault, 1994d, pp. 90-91): "Szasz has perfectly perceived the deep resonance between the control functions of medicine, psychiatry and the state structures of control put in place since the nineteenth century" (Foucault, 1994c, pp. 78). For his part, Szasz quotes and comments on Foucault's *History of Madness* in 1970 (*The Manufacture of Madness*, Szasz, 1981b, pp. 27, 29, 63, 116 , 137 and 317): "A study of the origins of madhouses in Europe during the 17th century shows clearly enough that [...] they were institutions similar to prisons, intended for the confinement of socially undesirable persons" (*Op. cit.*, p. 137). Also

> will write a contribution to the collective book *Crimini di pace* in support of Basaglia [...]. In any case, even though he responded *in the least* [...] to the requirements concerning the anti-psychiatric action, Foucault nevertheless partially recognized himself in such struggles (Eribon, 1992, p. 175).

Foucault made some other comment to show that, perhaps, his texts would have inspired the anti-psychiatry movement although he, personally, had little to do with it:

> I am attached to this book, of course, because I wrote it, but also it has served as a *tool-box* for different people, like the psychiatrists of British antipsychiatry, like Szasz in the United States, like sociologists in France: ils l'ont l'ont fouillé , ont trouvé un chapitre, une forme d'analyse, quelque chose qui le leur a servir ultérieurement (Foucault, 1994a, p. 523).

Basaglia rejected the label of anti-psychiatrist and asserted his identity and status as a psychiatrist, as can be seen in these statements from the early 1970s:

> I categorically reject the qualification of "anti-psychiatrist". I am not interested in this scheme. I am a psychiatrist because I am aware of my duties; otherwise, I should change profession. If I continue to practice in the public sector, i.e. in the state sphere, it is because I am a psychiatrist.

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recommends its reading in his 1976 book *Schizophrenia, the Sacred Symbol of Psychiatry* (Szasz, 1984a, p. 181). Finally, in *Antipsychiatry: Quackery Squared* (2009), Szasz mentions Foucault's works *The Birth of the Clinic* and *Mental Illness and Psychology* (p. 178). In this book Szasz considers that Foucault is not an antipsychiatrist but reproaches him for not having firmly rejected the concept of mental illness nor supported the abolition of coercive psychiatry (p.p. 129-131).

because I accept my *status* as a psychiatrist, a *status* that has nothing to do with the conformism of the integrated intellectual, the intellectual and the technician who act with the consent of the public power and the social organization, and who act falsely from a democratic point of view. I think that, as a technician, I must simply use my *status* to help overcome the needs of the public and of the interned (Della Rocca, 1973, p. 10).

As we shall see below, it was Szasz who fought most vehemently to keep the label "anti-psychiatrist" away from himself. In an interview given in 1974a, to the question of whether he considers himself an anti-psychiatrist, he replies:

Certainly not. I have no control over what other people consider me or call me. I have been called much worse things. Though I think "antipsychiatry" is a pretty stupid term. I emphasize this, because language is important to me, as it must be to anyone who takes human affairs seriously. [...] But I do resent being called an antipsychiatrist. Why? For the same reason as a person opposed to rape but not to sexual activities between consenting adults would resent being called an "anti-sexualist." I oppose involuntary psychiatry, the "rape" of the patient by the psychiatrist; but I do not oppose voluntary psychiatry, psychiatric activities between consenting adults. [...]
[Antipsychiatrists confuse the two forms of psychiatry] in several ways. First, by assenting to the proposition that all of psychiatry is equally bad: that's implicit in the term "antipsychiatry." Second, by adopting my view that, for example, schizophrenia is not a bona fide disease, and then offering their own form of "therapy" and "cure" for it: that, implicitly, negates the claim that what ails the alleged patient is not a disease. Third, by insisting that although mental patients are not sick, society is: that's merely inverting the despicable psychiatric name-calling (Szasz, 1974a, pp. 6-7).[126]

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(126) "Certainly not. I have no control over what other people call me or what they think of me. I have been called many worse things. I consider 'anti-psychiatry' to be a rather stupid term. I emphasize

The following can be concluded from the above:

1. First and foremost, anti-psychiatry was a political movement against the traditional principles, methods and institutions of psychiatry that emerged, as such, in Great Britain from the work of practicing psychiatrists such as Ronald Laing and David Cooper and the alternative experiences they implemented (Villa 21 and Kingsley Hall). In such therapeutic communities, madness was recognized as an authentic way of being and rebelling against repressive society. The psychiatrists who participated in them renounced their classical therapeutic function and became facilitators of what was called the "inner journey", was in keeping with the countercultural modes of the time.

2. Cooper used the term "anti-psychiatry" in 1967 and organized the *Dialectics of Liberation Congress* in 1968 together with other self-styled anti-psychiatrists such as Laing, Redler and Berke. If other authors such as Szasz, Foucault or Goffman have been

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This is because language is important to me, as it should be to anyone who takes human affairs seriously. [...] But I resent being called anti-psychiatrist. Why? For the same reason that a person who opposes rape but not sexual practices between consenting adults would be offended to be called 'anti-sexualist'. I oppose involuntary psychiatry, the 'rape' of the patient by the psychiatrist, but I do not oppose voluntary psychiatry, psychiatric activities between consenting adults. [...] [Antipsychiatrists confuse the two forms of psychiatry] in several ways. First, by agreeing with the idea that all psychiatry is equally bad: that is implicit in the term 'anti-psychiatry'. Second, by adopting my idea that, for example, schizophrenia is not a *bona fide* disease and then proposing its own forms of 'therapy' and 'cure' for it: that denies, implicitly, the claim that what ails the so-called patient not a disease. Third, by insisting that, although mental patients are not sick, society is, which is simply to reverse the despicable psychiatric offense."

considered anti-psychiatrists only because they agreed with Laing and Cooper in denouncing involuntary commitment to psychiatric hospitals and the practices carried out there. No doubt the English anti-psychiatrists were able to draw on the epistemological, historical and sociological research of Szasz, Foucault and Goffman. However, none of these authors called themselves "anti-psychiatrists" or engaged in experiments similar to those undertaken by them. It was Basaglia, in Italy, who was the only one bring about effective political and legislative change with respect to state psychiatric care.

3. Because of their left-wing political ideology, it could be said that Foucault and Basaglia coincided with their European colleagues Laing and Cooper, but not so the North Americans Goffman and Szasz. On the other hand, Goffman only entered a psychiatric hospital to conduct his field study, and Szasz and Foucault did so punctually when they were psychiatry and psychology students (Szasz, 2009; Novella, 2008). In contrast, Laing, Cooper and Basaglia did practice as psychiatrists and worked in psychiatric hospitals.[127]Neither Foucault, Goffman nor Szasz proposed reforms in psychiatric care. The latter two fought for the abolition of institutionalization and involuntary psychiatric treatment. In contrast, Laing, Cooper and Basaglia did not advocate the abolition of psychiatry but its reform: the transition from the hospital to the community. Basaglia was the promoter of the Italian psychiatric reform, and Laing, Cooper and their British colleagues Redler and Berke conducted community "therapeutic" experiments (e.g., Kingsley Hall) that were properly anti-psychiatric.

In short, the anti-psychiatry movement must be confined to a place (London), an era (the 1960s), and psychiatrists who called themselves anti-psychiatrists and

[127]Laing at the *Gartnavel Royal Hospital* (Glasgow) and the *Tavistock Clinic* (London); Cooper at the *Shenley Hospital* (London), among others; and Basaglia in Gorizia and Trieste.

who, influenced by Marxism and existentialism, formulated a particular way of conceiving madness and experimented with its treatment in therapeutic communities with very particular methods. The anti-psychiatric movement coincided with the spirit of the May '68 era, specifically in the elimination of all types of authority (epitomized in the asylum) and the implementation of community alternatives guided by the motto "forbidden to prohibit". The founders and true representatives of anti-psychiatry were Laing, Cooper and other British psychiatrists: "In Great Britain, R.D. Laing was considered the true father of this movement" (Nasser, 1995, p. 744). Basaglia was not a countercultural anti-psychiatrist but a reformer of psychiatry: he succeeded in getting the asylums closed in Italy and supported the opening of psychiatric wards in general hospitals as well as outpatient psychiatric care. The works of Foucault, Goffman and Szasz could have served as a point of support for the anti-psychiatrists, but it was never in the spirit of these authors to belong to the anti-psychiatry movement, nor did they ever take *credit for* it. However, because of their agreement with Laing and Cooper in their criticisms of traditional psychiatry, they were quickly and unjustifiably labeled anti-psychiatrists. I consider this to be a monumental error that is still endlessly repeated today. If one analyzes the history of anti-psychiatry and the works of its supposed founders, one can only consider Szasz, Foucault and Goffman as unwitting inspirers of the positions that were later adopted by the true and authentic British anti-psychiatrists.

In specific case of Szasz, what Antonio Escohotado says in the prologue to the Spanish version of *El mito de la enfermedad mental*, "[This work] also constitutes the founding act of anti-psychiatry, later developed by Laing and Cooper" (Escohotado, 1999, p. 13), can be taken as valid, provided that "act" is not understood in its literal sense,

as the official certification of a fact, but as an influence or source of inspiration. Similarly, Obiols (1973, p. 39) points out that *The Myth of Mental Illness*, "chronologically, can be considered as the source of the anti-psychiatric movement from the conceptual point of view". In fact, if we attend to what has been exposed in the previous chapter and compare it with the way of thinking and acting of the British anti-psychiatrists presented here, we cannot but conclude that Szasz has nothing to do with it: he was not left-wing, he was not an "anti-establishment", he did not participate in the hippy counterculture, he was not a reformer of psychiatry, he did not prescribe drugs as facilitators of the "inner journey", nor did he support community psychiatry. In fact, he was just the opposite: liberal-conservative, opposed to any form of socialism, an abolitionist (not a reformist) of psychiatry, an advocate of the ethics of individualism and private psychotherapy rather than community psychiatry, and, although he fought for individual freedom in drug use, he never recommended their use. Despite the clear differences with the British anti-psychiatrists, Szasz did not manage to shed such a label as the reader of any of the manuals and articles, current or past, on the anti-psychiatry movement will be able to verify. Thus, in a 1973 article, Sir Martin Roth, an eminent British psychiatrist, states:

> The [antipsychiatric] movement has fostered some unlikely alliances between groups of sociologists, psychologists, psychoanalysts and Marxist critics of contemporary Western society, such as Marcuse. [...] The writings of the most articulate spokesmen, Szasz (in the United States), Laing and Cooper (in Great Britain) and Basaglia (in Italy) have [...] reached a mass public (Roth, 1973, p. 373).

Roth rightly attributes to Laing, Cooper and Basaglia links with Marxist ideology. What is surprising is that he identifies Szasz with that political tendency when the latter showed, from his earliest writings, a firm opposition to socialism. Roth follows the

following reasoning: Laing, Cooper and Basaglia criticize psychiatry and are Marxists. Therefore, they are anti-psychiatrists. Szasz criticizes psychiatry. Therefore, Szasz is a Marxist and an anti-psychiatrist. If the terms "critique of psychiatry," "Marxism," and "anti-psychiatry" are synonymous, it could be said, following the same logic, that Szasz criticizes psychiatry but is not a Marxist; therefore, Szasz is not an anti-psychiatrist. Thus, without intending to do so, Roth would disassociate Szasz from the anti-psychiatry movement. Roth continues:

> Szasz says that the psychiatrist is not the doctor he pretends to be but is the symptom of a social disease. There is no mental illness because we are all engulfed by a social malady which debases and distorts human relationships. Nor are there any patients; we are all victims. No clinics or treatments are required, because society is the real patient and it requires treatment of a radical kind (Roth 1973, p. 374).

These statements are surprising because, unlike Laing and Cooper, Szasz never blamed capitalism for the ills of the individual nor did he say that this society was sick. He does not support victimhood but, on the contrary, autonomy and individual responsibility. He is not a radical social revolutionary but a radical individualist. He was undoubtedly the most active and stubborn of those who advocated the abolition of psychiatry (the coercive institutional one, not the private and consensual one) but he never named himself, nor wanted to be named, spokesman for anti-psychiatry. Roth's words represent what Szasz lamented, that anti-psychiatrist is not only the one who names himself as such but also the one whom other people consider anti-psychiatrist (Szasz, 2009, p. 29). As we will see in the next epigraph, Szasz took it upon himself to demonstrate that the only antipsychiatrists were those who chose to define themselves as such: Laing, Cooper and their fellow travelers.

3.2. SZASZ'S CRITICISMS OF ANTIPSYCHIATRY

Szasz approached his formal critique of antipsychiatry in two stages. He first wrote an article on antipsychiatry in 1976, "Anti-Psychiatry: The Paradigm of the Plundered Mind"[128], which he later included in his book *Schizophrenia: The Sacred Symbol of Psychiatry* (Szasz, 1984a, pp. 49-79). In the same year, he gave a lecture at the University of Essex entitled "Paresis and Plunder: The Models of Madness in Psychiatry and Anti-Psychiatry". In these interventions Szasz harshly criticized the approaches of antipsychiatry and stated that he had nothing to do with such a movement.

The second stage in which Szasz dealt with antipsychiatry began 27 years later with the publication of his article "The Cure of Souls in the Therapeutic State" (Szasz, 2003), followed by others: "Knowing What Aint't So" (Szasz, 2004), "Debunking Antipsychiatry: Laing, Law and Lagarctil" (Szasz, 2008b) and "Anti-Coercion is not Anti- Psychiatry" (Szasz, 2008c). This series of articles culminated in the publication of his penultimate book, *Anti-Psychiatry Quackery Squared* (Szasz, 2009). In these writings, Szasz reprints his 1976 criticisms of antipsychiatry and adds, based on the accounts of people who knew them, a crude portrait of Laing's personality and that of other antipsychiatrists. At this stage, Szasz is no longer content to show that his propositions have nothing to do with those of the anti-psychiatrists, but rather to point out the character, despicable in his opinion, of the latter, specifically that of Cooper: "Cooper hates individualism, private property and the free market and loves collectivism, communism, victims and the prefix *anti*" (Szasz,

[128]*The New Review*, *3*, (29), August 1976, pp. 3-14.

2009, p. 33); and, above all, that of Laing: "From my point of view, Laing was an enemy personal responsibility, individual freedom and free society. He was a bad person and fraud as a professional" (*Op.cit.*, pp. 82-83); "I have always considered Laing's moral conduct (excessive drinker, supplier of LSD to his colleagues and patients; promiscuous participant in fashionable trends, from Buddhism to 'renaissance', quarrelsome, violent, father of ten children for whom he takes no responsibility) shameful and reprehensible" (Szasz, 2004, p. 341); "I cannot think of anyone who knew him who was not offended by him at one time or another" (account by Australian psychotherapist Jan Resnick quoted by Szasz, 2009, p. 106).

Apart from this change of tone in the second stage, there are no significant differences in what was said about antipsychiatry in these seven writings.[129]In all of them, Szasz insistently repeats his main arguments seasoned with multiple examples aimed at convincing us of the soundness of his positions. My intention in this section is to outline the main points that Szasz made in his critique of antipsychiatry in order to determine whether, as he argued, it can be concluded that it did not merit

[129]Laing did not devote as many pages to Szasz. In a 1979 article explicitly entitled "Round the bend", Laing comments on three books by Szasz (*Schizophrenia: The Sacred symbol of psychiatry* (1976), *The Theology of Medicine* (1977) and *The Myth of Psychotherapy* (1978)). In it, Laing evaluates Szasz's work, thought and person:

We miss in these books any in-depth analysis of the structures of power and knowledge such as we find in Foucault and Derrida. It is a pity about Szasz. He is so insulting and abusive that it is almost embarrassing to find oneself agreeing with him sometimes. As the years have gone by, the important points have become so shrouded in a smoke screen of such garbled dogmatism and arrogance as to be almost inaccessible. He now seems to believe that an insult is an argument, and that his assertions are self-validating proofs of their own truth (Laing, 1979).

the label of anti-psychiatrist. I will not dwell here on the account of Cooper's and Laing's outrages, since I consider that they do not contribute anything substantial to the purpose of this thesis. I recommend the reader interested in these lurid details to turn to some of the sources Szasz consulted, especially the newspaper article "Far Out" (Gale, 2001) in which David Gale, Cooper's patient, narrates how Cooper behaved in his work (referenced in Szasz, 2009); the book *Zone of Interior* (Sigal, 1976) in which Clancy Sigal, Laing's patient at Kingsley Hall, describes how Laing acted in that community (referenced in Szasz, 2008b, 2008c and 2009); and the biographies of Laing written by his son Adrian (Laing, 1994) (referenced in Szasz, 2003, 2004 and 2009), by Bob Mulan (2000) (referenced in Szasz, 2009) and by John Clay (1996) (referenced in Szasz, 2008b and 2009) in which the authors give evidence of Laing's abrupt personality and his particular practices as a psychiatrist. Suffice it to say that Laing lost his medical license in 1987 following a complaint from a patient who accused him of treating her drunk and being aggressive towards her.

In his article "Antipsychiatry: the model of the plundered mind", Szasz defends the thesis that, no matter how much antipsychiatrists question the concept of mental illness, they still propose ways of treating it and, for that reason, they are no different from other psychiatrists. He states that "for a long time I have maintained [...] that if there is no illness, there is *nothing to* treat, if there are no patients, there is no *one to* treat" (Szasz, 1984a, p. 51). For Szasz, psychiatry and anti-psychiatry coincide in considering the patient as a victim, either of a mental illness (psychiatry) or of an authoritarian family and an insane and oppressive society (anti-psychiatry) (*Op.cit.*, p. 53).[130]Likewise

(130) "The conception of alienation as a product of social and family origin, arising from certain environmental conditions that create it as a response mechanism to certain environmental pressures.

Just as psychiatry is based on an intellectual misunderstanding (the consideration of life's problems as illnesses), anti-psychiatry erroneously interprets the behavior of the insane as something authentic. Szasz criticizes both psychiatric practices, namely the justification of confinement in the asylum under the guise of medical treatment, and anti-psychiatric practices that justify the "virtuous" behavior of the madman as a result of the "vicious" behavior of his environment (*Op.cit.*, p. 74). He argues that all these pretexts are pure hot air and that what should be done is to denounce concretely the coercive psychiatric practices and to defend "that the phenomenon that psychiatrists call 'schizophrenia' is not a demonstrable medical illness, but the name of a certain kind of social deviation (or, rather, an unacceptable behavior for those who pronounce it)" (*Op.cit.*, p. 63).

To demonstrate that anti-psychiatry follows the same medical model as psychiatry in the treatment of a so-called mental illness, Szasz takes as an example the 1965-1969 report of the *Philadelphia Association*, a charitable institution founded by Laing and Cooper whose flagship was *the Kingsley Hall* residence where there were "no staff, no patients, no institutional procedures" and where "people get up or stay in bed as they wish, eat what they want when they want, stay alone or with others, and generally make their own rules" (*Philadelphia Association Report 1965- 1969* cited by Szasz, 1984a, p. 61). See below some of the *Philadelphia Association*'s objectives contained in that report:

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surrounding environment is the main or most prominent characteristic of what is known as the *antipsychiatry*" (Obiols, 1973, p. 25).

To alleviate mental illnesses of all kinds, particularly schizophrenia.

To deal with, or even investigate, the causes of mental illnesses, the means of detecting and preventing them, and their treatments.

To provide and encourage the provision of residential accommodations for persons suffering, or who have suffered, from mental illness.

To provide monetary assistance to poor patients.

To promote and organize training to treat schizophrenia and other forms of mental illness (*Ibid.*).

It is evident that these anti-psychiatric premises are opposed to those held by Szasz, who considers that such a philosophy allows and encourages infantilism in people, which is contrary to the mature and ethical performance of adult members of any society. Such a paternalistic stance of anti-psychiatrists is also "the cornerstone of the ideal model of medical ethics" (Szasz, 1984a, p. 62), i.e., the ethics of care, as distinct from the ethics of autonomy and individualism advocated by Szasz.

In the four articles that inaugurate the second stage of his critique of anti-psychiatry (Szasz, 2003, 2004, 2008b and 2008c), Szasz resorts to different examples from Laing's life and work that portray him as an incoherent, lying and perverse person. Szasz wants to show that Laing did not oppose, as he did, involuntary hospitalization, which, in his view, confirms the similarity between anti-psychiatrists and conventional psychiatrists and the essential difference with respect to the positions he advocates. To this end he endlessly quotes a passage from *The Divided Self* in which Laing says: "When I certify that someone is mentally disturbed, I am not using equivocal words when I write that he is mentally deranged, that he may be dangerous to himself and others, and that he needs care and attention in a hospital for the mentally ill" (Laing, 1993, p. 23). By

On the other hand, Szasz believes that both anti-psychiatric proclamations and the term "anti-psychiatry" itself have done a disservice to psychiatric criticism because they have been used as an alibi by psychiatrists to quickly discredit anyone who, like himself, rigorously questions the foundations and practices of conventional psychiatry:

> As a result of the anti-psychiatrists' self-seeking sloganeering, psychiatrists can now do what no other members of a medical specialty can do: they can dismiss critics of any aspect of accepted psychiatric practice by labeling them "anti-psychiatrists." The obstetrician who eschews abortion on demand is not stigmatized as an "anti-obstetrician." The surgeon who eschews transsexual operations is not dismissed as an "anti-surgeon." But the psychiatrist who eschews coercion and excuse-making is called an "anti-psychiatrist" (Szasz, 2008c, p. 27).[131].

Everything that Szasz exposes in these four articles is later collected in his book *Antipsychiatry: Quackery Squared* (Szasz, 2009), which can be considered a final compendium of Szasz's criticisms of antipsychiatry and its representatives. In the following, and to conclude this epigraph, I will quote some quotations from this book that serve as examples of the theses defended by Szasz, namely: a) that the term "antipsychiatry" has served as a weapon against serious critics of psychiatry; b) that because of his critical work against the

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(131) "As a result of the creation of self-congratulatory slogans by anti-psychiatrists, psychiatrists can now do what no other member of a medical specialty can: smear critics of any aspect of conventional psychiatric practice by labeling them 'anti-psychiatrists.' The gynecologist who refuses to perform abortions on demand is not stigmatized as 'anti-gynaecologist'. The surgeon who refuses to perform sex-change operations is not smeared as 'anti-surgeon'. But the psychiatrist who refuses to practice coercion and offer exculpatory alibis is labeled 'anti-psychiatrist'."

(b) that psychiatry and antipsychiatry are one and the same thing; and (c) that psychiatry and antipsychiatry are the same thing.

> [In the early 20th century] the term *"Antipsychiatrie"* served as an effective barrier against the arguments of persons opposed to the increasing use by the state of a novel medicalized form of legal compulsion. [...] [With its reinvention in the 1960s by antipsychiatrists], the easy availability of this term as a dismissive label prevented serious psychiatric criticism from receiving a fair hearing in both academia and the media. That is the accursed legacy of the so called antipsychiatry movement (Szasz, 2009, p. 151).[132]

> Although my critique of the alliance of psychiatry and the state antedates by two decades the reinvention and popularization of the term "antipsychiatry," I was smeared as an antipsychiatrist, and my critics wasted no time identifying and dismissing me as a "leading antipsychiatrist" (*Op.cit.*, p. viii).[133].

> Laing and his followers managed to confuse the language of psychiatric criticism to a far greater extent than contemporary writers on the subject realize. They set up a false dichotomy between conventional psychiatric practitioners and themselves, obscuring that psychiatry and

(132) "[In the early twentieth century] the term *'Antipsychiatrie'* served as an effective barrier against the arguments of people who opposed the state's increasing use of a new and *medicalized* form of legal coercion. [...] [With its reinvention in the 1960s by anti-psychiatrists], the easy availability of this term as a derogatory label prevented serious psychiatric criticism from receiving fair attention in both academia and the media. This is the cursed legacy of the so-called anti-psychiatry movement."

(133) "Despite the fact that my criticism of the alliance of psychiatry and the state preceded by two decades the reinvention and popularization of the term 'antipsychiatry,' I was maligned as an antipsychiatrist and my critics were quick to identify and discredit me as one of the 'leading antipsychiatrists.'"

antipsychiatry are two sides of the same coin. As a result, henceforth, anyone who addresses the subject of psychiatry becomes categorized as for or against psychiatry -propsychiatry or antipsychiatry. I criticize both psychiatry and antipsychiatry and am stigmatized as a "leading antipsychiatrist."

[Antipsychiatrists engage in the same practices as do psychiatrists: they embrace the medical-therapeutic categorization of the human problems they "treat," often under the auspices of the National Health Service or other government-funded organizations (such as Soteria Houses), although they often say they do not. They use coercion and drugs, although they often say they do not.* In his autobiography, Laing writes, "To say that a locked ward functioned as a prison for non-criminal transgressors is not to say that it should not be so. [...] This is not the fault of psychiatrists, nor necessarily the fault of anyone. [...] It does not follow from such possibly disturbing considerations that the exercise of such [psychiatric] power is not desirable and necessary, or that, by and large, psychiatrists are not the best people to exercise it, or, generally, that most of what does happen in the circumstances is not the best that can happen under the circumstances." This was not my view of psychiatric incarceration. Nevertheless, antipsychiatrists were eager to claim me as one of their own, while psychiatrists were dismissing me as a "popular sixties type of guy, an anti-establishment rebel." (*Op.cit.*, p. 40).[134]

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(134) "Laing and his followers succeeded in confusing the language of psychiatric criticism to a far greater degree than current writers on the subject realize. They set up a false dichotomy between the practitioners of mainstream psychiatry and themselves, concealing the fact that psychiatry and antipsychiatry are two sides of the same coin. As a result, from here on out, anyone who addresses the issue of psychiatry will be categorized as either pro- or anti-psychiatry (pro-psychiatrist or anti-psychiatrist). I criticize both psychiatry and anti-psychiatry but am stigmatized as a 'prominent anti-psychiatrist'.

[...] Antipsychiatrists engage in the same practices as psychiatrists: they embrace the medical-therapeutic categorization of the human problems they 'treat', even under the auspices of the *National Health Service* or other government organizations (such as *Soteria Houses*), even though they often claim to

3.3. POSTPSYCHIATRY: A NEW ANTIPSYCHIATRY?

As the anti-psychiatry movement disappeared, a movement of users of psychiatry progressively emerged (Nasser, 1995, p. 745-746) that began to fight against the stigmatization caused by psychiatric diagnoses and against coercive psychiatric practices such as indiscriminate pharmacological treatments and involuntary hospitalizations (Rissmiller and Rissmiller, 2006, p. 863).

The current psychiatric current that supports these claims is called "postpsychiatry". The main proponents of postpsychiatry are psychiatrists Patrick

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they don't. They use coercion and medication, even though they often say they do not.* In his autobiography, Laing writes, 'To say that a locked cell functioned as a prison for non-criminal transgressors is not to say that it should not be so. [...] This is not the fault of psychiatrists, nor is necessarily anyone's fault. [...] It does not follow from such possibly disturbing considerations that the exercise of such [psychiatric] power is not desirable and necessary, or that, broadly speaking, psychiatrists are not best placed to exercise it, or, generally, that much of what happens under certain circumstances is not the best that can happen under such circumstances.' That is not my view of psychiatric incarceration. However, the anti-psychiatrists were eager to hail me as one of them, while the psychiatrists dismissed me as 'a popular guy in the sixties, an anti-establishment rebel.'"

*Note: According to Obiols (1973, p. 29), a "basic premise of antipsychiatry is the suppression of pharmacological treatment".

Bracken and Philip Thomas,[135]founding members of the *Critical Psychiatry Network*, a collective to which I will refer in the next chapter. The articles "Beyond Liberation: Michel Foucault and the Notion of a Critical Psychiatry" (Bracken, 1995) and "Postpsychiatry: A New Direction For Mental Health" (Bracken and Thomas, 2001) can be considered inaugural texts of postpsychiatry although the term was coined by Peter Campbell (Campbell, 1996) as certified by Kecmanovic (2009) and Thomas and Bracken themselves (2004). These articles of were followed by other writings (e.g., Thomas and Bracken, 2004; Bracken and Thomas, 2004, 2005, 2006 and 2009; Double, 2009; or Bracken, 2012) that maintain the same line of argument.

Postpsychiatry is the name chosen to describe a postmodern and renovating proposal of psychiatry (Kecmanovic, 2009, p. 276) inspired by Foucault's thesis (1976) according to which the emergence of modern psychiatry, as a branch of medicine, is not the result of a scientific but a political fact: the internment of people considered "irrational" in asylums (Bracken and Thomas, 2001, pp. 724-725). Following Foucault, Bracken and Thomas argue that 20th century psychiatry was born and grew up blindly embracing the rationalist program of modernity that denied any hint of authenticity to the irrational discourse of the madman (*Op.cit.*, p. 725). In this sense, the main purpose of postpsychiatrists is that attention be paid to this discourse and to the demands of

[135]Patrick Bracken is Clinical Director at the *West Cork Mental Health Service* (Ireland) and Professor of Philosophy, Diversity and Mental Health at the *University of Central Lancashire* (UK). Philip Thomas retired in 2004 from his work as a psychiatrist in the British *National Health Service*. He was also Professor of Philosophy, Diversity and Mental Health at the *University of Central Lancashire* and is currently Honorary Professor in the Department of Social Sciences and Humanities at *the University of Bradford* (UK).

The protagonists are considered citizens in their own right, "experts by experience", and not ignorant and annoying people who should be removed from society. To do so, psychiatrists will have to abandon the traditional medical model in which they have been trained.

> Our argument is that our models (especially the medical model) are part of the problem [...]. The citizenship agenda [as a synonym for postpsychiatry] recognizes the importance of better treatments and services. It supports campaigns against discrimination and stigma. But it also works to bind these to increasing demands from user groups for spaces in which some fundamental assumptions about mental health can be questioned (Bracken and Thomas, 2004).

The concrete proposal of postpsychiatry is that a critical debate on psychiatric practices should be inaugurated in which both *clinicians* and the user movement participate on equal terms (Bracken, 2012, p. 55):

> What is important here is the emergence of a *very different* way of thinking about madness, diagnosis and treatment. It is not simply a restatement of antipsychiatry. [...] They [user associations] want a psychiatry that can think outside the language of psychopathology and that can respect the expertise that they have gained through their personal and communal struggles. [...] We have argued for years that it is possible for us to work *as doctors* with those who experience 'madness' and severe distress in ways that respect the complexity of these states and diverse ways of making sense of them. Postpsychiatry' is an attempt to start thinking about how this might be possible. [If we are to engage in dialogue with users, survivors and carers about the benefits and limitations of these different approaches, we must engage respectfully with a diversity of frameworks and understand their values, assumptions and priorities. (Bracken and Thomas, 2009, p. 242). (Italics mine).

The purposes of such patient coalitions, seconded by the so-called postpsychiatrists, seem to share some of the principles of the anti-psychiatry movement (Cf. Whitley, 2012, pp. 1039-1041) whose main goals were, as I have shown above, to give public visibility to the insane (normalization) and to change the traditional psychiatric model (exemplified by institutionalization) to care in the community. While acknowledging the theoretical and political influence of antipsychiatry, Bracken and Thomas assert that postpsychiatry differs methodologically from it in its practical implications since it "does not seek to replace the medical techniques of psychiatry with new 'liberating' therapies," this being said in reference to Laing and Cooper's communal experiments (Bracken and Thomas 2001, pp. 727). However, like Whitley, other authors see the project of postpsychiatry "as strikingly similar to that of the antipsychiatry movement" (Holloway, 2009, p. 244), in that postpsychiatrists:

> Question the validity of the biomedical model, criticize positivism and reductionism of modern psychiatry, normalize madness, disapprove of decontextualization when diagnosing mental disorders (against methodological individualism), point out the serious limitations of scientific methods in psychiatry, underlie the importance of values and meanings in grasping mentally ill people, and analyze the downsides of the 'great confinement' as well as other repressive aspects of psychiatric practice (Kecmanovic, 2009, p. 276).

In my opinion, these comments are based on the common prejudice that all criticism of psychiatry *is* antipsychiatry. I do not consider a program such as the one outlined in the above quote to be exclusive to antipsychiatry or postpsychiatry but rather to the global field of psychiatric criticism of which the antipsychiatry of the 1960s or the current postpsychiatry would be the most socially and politically action-oriented strands.

always from a communitarian ideological framework. What really distinguishes postpsychiatry is its insistence on the need to give a voice to patients represented by different associations of users and survivors of psychiatry[136]such as, among many others, *Hearing Voices Network* (which has formal links with *Critical Psychiatry Network*), *The Paranoia Network*, *Self-Harm Network*, *The Icarus Project or Mind Freedom*,[137]very active on the Internet, in the media and through the organization of campaigns.

[136]In this thesis I will only point out the main objectives pursued by the movement of users and survivors of psychiatry. For a full account of their history see the archive of Anne Plumb (1970-2009) (http://studymore.org.uk/arcap.htm); the archive of Valerie Argent and Andrew Roberts (1962-1973) (http://studymore.org.uk/arcaandv.htm); and, above all, the historical archive of *Mental health and survivors' movements and context* (1772-act.) (http://studymore.org.uk/mpu.htm#Asylumbox). On the other hand, Peter Campbell (2005) provides a good summary of the history (from the 1970s to 2005), aims and achievements of the movement.

[137]For example, Carney (2012) reports that, in the summer of 2003, six psychiatric survivors began a hunger strike in protest against coercive psychiatric practices, the absence of solid scientific evidence to support psychiatric treatments and the links between the State and the pharmaceutical industry. The American association *Mind Freedom* supported this hunger strike with the publication of a statement denouncing the impunity of psychiatrists when they imprison those who have committed no crime; impose diagnostic labels that stigmatize people; cause neurological damage by means of powerful psychotropic drugs that induce the violent and suicidal behaviors they supposedly want to combat; destroy the brain with electroshocks; etc. *Mind Freedom* sent this statement to *The American Psychiatric Association* (APA), *The National Alliance for the Mentally Ill* (NAMI) and the Surgeon General's office, demanding that these practices be stopped and demanding evidence to scientifically support the reliability and validity of the research aimed at establishing diagnoses and demonstrating the efficacy of psychiatric treatments. Or, if not, to admit publicly that they are unable to provide such evidence (*Mind Freedom*, 2003a). Only the APA sent a brief response (http://www.mindfreedom.org/kb/act/2003/mf-hunger- strike/hunger-strike-debate/apa-1st-reply-to-mfi) in which they only stated, citing some literature sources, that such evidence exists. Subsequently, *Mind Freedom* (2003b) replied to the APA

and public acts of protest such as the Mad Pride demonstrations. These associations are calling for the normalization of madness and for their demands, based on their personal experiences, to be heard and taken into account when mental health policies are established. Specifically, they are fighting to resolve the contradiction that exists in a health system that claims to seek greater control of users over their lives but, at the same , does not cease to grant psychiatrists powers to commit and treat people against their will (Campbell, 2005, p. 81).

As representatives of these protests, postpsychiatrists question, as did the early critics of psychiatry (Szasz, Foucault, Goffman and Laing), coercive psychiatric policies. Bracken agrees with Szasz and other critics of psychiatry in denouncing the justifications used for the exercise of psychiatric power:

> The decision-making powers that are currently given to psychiatry cannot be justified on either scientific or moral grounds. [...] The logic for psychiatric power would appear to be:
>
> - States of madness and distress are the result of episodes of mental illness.
> - Mental illness can be fully grasped in the logic of medicine and thus doctors are uniquely positioned to explain and to predict the outcome of such episodes.
> - Psychiatry possesses a range of treatments that are uncontroversially of benefit to its patients.
> - It is therefore justified to give psychiatrists the power to both detain and to treat patients without their consent.

The organization sponsors many such campaigns, such as the "Mad Pride" protest marches that have been held around the world since 1993. This organization sponsors many campaigns of this type, such as the "Mad Pride" protest marches that have been held around the world since 1993. For more information, visit http://www.mindfreedom.org/.

> The assertion here is that *psychiatric science leads to psychiatric power.* Thomas Szasz has challenged this position for over half a century [...] According to Szasz and historians like Roy Porter, *psychiatric power led to psychiatric science* (Bracken, 2012, pp. 55-56).

However, unlike Szasz and Goffman, postpsychiatrists do not advocate the abolition of all institutional psychiatry but maintain an ambiguous position in this regard. Despite criticizing, as we have seen, the justifications for psychiatric power, Bracken and Thomas understand that there are certain exceptions (which they do not specify) that justify the use of force and coercion of patients by psychiatrists:

> *This is not to say that society should never remove a person's liberty because of their mental disorder*. However, by challenging the notion that psychiatry theory is neutral, objective, and disinterested, postpsychiatry weakens the case for medical control of the process. Perhaps *doctors should be able to apply for detention* [...], *but not make the decision to detain someone* (Bracken and Thomas, 2001, pp. 726, my italics).

This surprising assertion, so contradictory to the previous one, coincides, indeed, with what Laing, one of the great critics of involuntary psychiatric confinement, pointed out in his autobiography:

> Mental hospitals and psychiatric units admit, routinely, every day of the week, people who are sent "in" for non-criminal conduct, but *for conduct which their nearest and dearest relatives, friends, colleagues and neighbours find insufferable*. [...] It is our only way to keep people out of the company that can't stand them. [...] To say that a locked ward functions as a prison for non-criminal transgressors is not to say it should not be so. *Our society may continue to 'need' some such prisons for unacceptable persons*. As our society functions at present such

> places are indispensable. This is not the fault of psychiatrists, not necessarily the fault of anyone. [*It does not follow* from such possibly disturbing considerations *that the exercise of such [psychiatric] power is not desirable and necessary*, or that, by and large, psychiatrists are not the best people to exercise it, or, generally, that most of what does happen in the circumstances is not the best that can happen under the circumstances (Laing, 1985, pp. 5-6, my italics).

What is expressed in these last two quotations is absolutely contrary not only to the protest of the movement of users and victims of psychiatry that postpsychiatrists claim to support, but also to the positions of Szasz who, from his liberal convictions, does not admit any justification for anyone, especially the State, to coerce innocent people.

In September 2012, the journal *History of Psychiatry*[138]published Szasz' last article, "Varieties of Psychiatric Criticism" (Szasz 2012).[139]This issue of *History of Psychiatry* was released the same month that Szasz died (September 2012). Both for this chronological reason and for its content, we can consider this article his intellectual testament in terms of criticism of psychiatry. In it, Szasz states for the last time and with the rotundity and clarity he always showed, that the only possible vindication of any kind of psychiatric criticism worthy of the name is the definitive and unconditional abolition of institutional psychiatry:

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[138]Magazine edited by Professor Germán Berrios, to whom I will refer in the following chapter.

[139]This is the printed version of Szasz's speech at the annual meeting of *the International Society for Ethical Psychology and Psychiatry* in Los Angeles, California, on October 28, 2011.

The CPN's [*Critical Psychiatry Network*] position is not psychiatric criticism, it is a plea for prettifying the psychiatric plantations. Psychiatrists either have the right to forcibly molest persons they call 'patients' by calling it 'medical treatment' or do not have such a right. As long as the psychiatrist is legally empowered to place his own personal interests and professional opinions ahead of those of the coerced citizen, regardless of 'safeguards' the 'patient' remains powerless vis-à-vis political-psychiatric despotism.

[...] From a contractarian-libertarian point of view, all contemporary psychiatric criticisms are misdirected. If a person is law-abiding, he and he alone should have the authority and power over his relations with others: no one should be able to do anything for or to him without his consent. Even if the subject has been convicted of lawbreaking, the authorities are not thereby justified in 'treating' him against his will for an alleged (non-contagious) illness, a punishment judges nowadays routinely authorize and impose.

[...] The psychiatric critic's primary duty is, and has always been, to reject the legal-political legitimacy of the use of psychiatric force and fraud. [...] The diverse problems that occupy the attention of psychiatric critics originate from a single source: psychiatric power. As long as so-called psychiatric services may be imposed on individuals against their will, efforts to 'reform' psychiatry distract from what must be our task, the abolition of every kind of involuntary psychiatric intervention. Being inseparable from coercion, psychiatry cannot be reformed. It must be abolished (Szasz 2012, pp. 353-355). [140]

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(140) "CPN's [*Critical Psychiatry Network*] position is not psychiatric criticism, but a call to embellish psychiatric plants. Psychiatrists either possess the right to forcibly violate people they call 'patients' under the guise of 'medical treatment,' or they do not possess such a right. As long as the psychiatrist is legally authorized to impose his personal interests and opinions on coerced citizens, the 'patient' remains unprotected and powerless in the face of psychiatric-political despotism.

[From a contractual-liberal point of view, all contemporary psychiatric criticism is wrong. If a person is law-abiding, she alone should govern her relations with others: no other should do anything, either by or for her, without her consent. Even if this person had been convicted of

To conclude this section, I would like to point out, in the form of a question, two fundamental contradictions in which postpsychiatrists and, in general, critical psychiatrists incur that remain to be resolved: How do they justify their criticism of the medical model and the classification of psychiatry as a natural science without themselves renouncing their identity as physicians?[141]and how do they justify the contradiction of criticizing involuntary hospitalizations and considering them pertinent on certain occasions?[142]

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a crime, the authorities lack justification for 'treating' her against her will because of an alleged (and not contagious) illness, a punishment that judges routinely impose and authorize today.

[...] The main task of the critic of psychiatry is, and always has been, to reject the political-legal legitimacy of the use of psychiatric force and deception. [...] The various problems that capture the attention of psychiatric critics have a single origin: psychiatric power. As long as so-called psychiatric services are imposed on individuals against their will, any effort to 'reform' psychiatry will distract us from what should our mission: the abolition of any kind of involuntary psychiatric intervention. Being inseparable from coercion, psychiatry cannot be reformed. It must be abolished.

[141]Basaglia, who presents himself as a physician, says: "Psychiatry as such is divided, it spreads out in an assistance that passes through the different branches of the social sciences. It spreads, not to rehabilitate, not to recover, but to return to 'normality' in the sense of placing people within the norm. [...] What happens is that psychiatry does not manage to provide an answer to normality (hence its extension to the human sciences) within its field, while medicine in general has been able to do so" (Della Rocca, 1973, p. 85).

(142) "Today [1973] there is already a clear idea of the serious damage caused by prolonged and indefinite hospitalization - totally unjustified outside the acute phases of the psychiatric disorder" (Obiols, 1973). The "acute phases" are still today the criterion for ordering hospitalization.

4. SZASZ AND PSYCHIATRY CRITICAL

4.1. FUNDAMENTALS OF PSYCHIATRY CRITICAL

In the second chapter I analyzed Szasz's work written between 1956 and 1965 in which he presents the theories and political positions he held without variation throughout his life as a philosopher and critic of psychiatry, as a theorist of psychotherapy and as a liberal intellectual. In order to demonstrate the constancy of his theories, I also quoted excerpts from some of his interviews and from some of the books he wrote in his last years of production. In the third chapter I dealt with his positions on antipsychiatry by referring to his two fundamental texts on the subject, "Antipsychiatry, the model of the plundered mind" (1976) and *Antipsychiatry: Quackery Squared* (2009), as well as to other articles prior to the publication of the latter book. In this fourth chapter I will analyze Szasz's work on the philosophy of psychiatry (leaving aside his political critique of psychiatry's coercive practices) and compare his postulates with those of later critics of psychiatry in order to clarify whether Szasz's thought may have had some influence on theirs. My initial answer is affirmative. I will try to demonstrate this and analyze why, in spite of this, Szasz is not conveniently recognized in current texts critical of positivist psychiatry.

After the rapid demise of the anti-psychiatry movement in the early 1970s, various groups of psychiatric users and patients emerged, and Franco Basaglia initiated the progressive transformation of institutional psychiatric care from psychiatric hospitals to general hospitals, outpatient clinics and community care. On the other hand, the utilization of

wild methods such as lobotomy, electroshock or insulin shocks. From the 1980s onwards, there was a progression in psychiatric "advances", supposedly revolutionary and hopeful (psychiatry was finally approaching the altar of medical science), such as the diagnostic classification initiated by *DSM-III*, the emergence of new psychopharmaceuticals that promised therapeutic effectiveness with far fewer side effects than the previous ones, and the data offered by neuroscientific research through neuroimaging techniques that supposedly confirmed the brain etiological thesis of psychic disorders. This supposed scientific revolution was politically supported and economically financed with the official declaration of the 1990s as "the decade of the brain" by US President George Bush (Bush, 1990). Currently, ten neuroscientists have proposed to declare the years 2012-2022 as "the decade of the mind" under the same positivist premises (Albus et al., 2007; Spitzer, 2008).

At the same time, a trend has emerged in recent decades that seriously questions positivism and organicism in psychiatry. For historical reasons that I will point out, this current can be generically named "critical psychiatry". As I have already mentioned, my intention is to show that what the current critics of biologistic psychiatry put forward is not very different from the criticisms put forward by Szasz since the middle of the twentieth century. In fact, Szasz is the only author who has been active, from the beginning though completely independent of the rest, in that critical process. In fact, I consider that Szasz deserves the appellation of "father of critical psychiatry" (and not of anti-psychiatry) for the following reasons: because he was the first to propose a systematic and rigorous critique of psychiatry; because of the number of years devoted to his mission as demonstrated by the volume of his work; because of his tireless dedication to defend his positions (even in opposition to other critics); because of the breadth of areas of knowledge he covered.

(history, ethics, sociology, psychology, medicine, anthropology, law, politics, epistemology, etc.); and, fundamentally, for being the only one who stood up against institutional psychiatry and demanded its abolition, which, in essence, differentiates him from the rest of the critics.

However, not only the defenders of official psychiatry but also the more informed authors whom I include here under the general heading of "critical psychiatrists" continue to make the mistake of calling Szasz an "anti-psychiatrist". I believe I have demonstrated that only Laing and Cooper (along with their British colleagues) deserve such an appellation. We must stop seeing Szasz as an anti-psychiatrist and come to regard him as one of several unwitting inspirers of psychiatrists. To definitively clear up this confusion, I consider it more appropriate to call Szasz, along with Foucault and Goffman, the "pioneers of critical psychiatry" (hereafter, "pioneers").

Since critical psychiatry is not a clearly definable homogeneous current, I consider it practical to establish two historical moments in the development of this trend which, beyond the different social contexts, form a continuum in which the authors of one stage are inspired by the work of those of the previous ones: a) the pioneers of the 1960s; and b) the current critical psychiatry born in the last quarter of the twentieth century. Having commented on the first stage in previous chapters, in this chapter I will focus on the second.

After the so-called anti-psychiatric critiques of the 1960s and some texts critical of classical psychiatry published in isolation in the last decades of the 20th century, today more and more psychiatrists, psychologists and other mental health professionals are joining forces with sociologists, philosophers and critics from various fields to question the scientific foundations of the biomedical model that prevails in psychiatry today, as well as the scientific basis of psychiatry.

their diagnostic categories, the validity of their research, the efficacy of their treatments and their links with the pharmaceutical industry, among other issues. Although it cannot be considered a cohesive movement but rather a diverse critical trend, it could be said that what unites these authors is the questioning of the scientistic reductionism in psychiatry and of the so-called biomedical paradigm that guides both the teaching of this discipline in faculties and its practice in hospitals. Duncan Double (2002, p. 902) summarizes the nine beliefs that have guided this psychiatric paradigm, also called neo-Kraepelinian:

- Psychiatry is a branch of medicine.
- Psychiatry should employ modern scientific methods and base its practice scientific knowledge.
- Psychiatry treats people who are sick and in need of treatment for their mental illness.
- There is a boundary between normal and sick people.
- Mental illness is not a myth. There are many mental illnesses. The task scientific psychiatry is to investigate the causes, diagnose and treat such mental illnesses.
- Psychiatric physicians should focus on the biological aspects of mental illness.
- There must be an explicit and intentional interest in diagnosis and classification.
- Diagnostic criteria must be codified, so an important part of the research should be devoted to validating these criteria by means of different techniques.
- Departments of psychiatry in medical schools should teach such criteria and not downplay them as has been the case for many years.

- Statistical techniques should be used in research to improve the reliability and validity of diagnoses and classifications.

Numerous authors critical of this positivist model consider that it should be replaced by another that contemplates the possibility of multiple causes (not only biological) in these disorders and "humanizes" the practice of psychiatry by paying greater attention to the subjective and contextual factors of the affected person than to the supposed objectivity of his or her brain functioning. Another differentiating feature between the two orientations is that while the biomedical model only includes psychiatrists and neuroscientists, critical psychiatry, oriented within a psychosocial framework, admits contributions from any area of knowledge.

There are hundreds of articles that could be included under the heading "critical psychiatry". It is not my intention to make an exhaustive review of them but to show the main concerns and propositions of this trend, specifically in its philosophical aspects (epistemological, ethical and conceptual analysis) and not so much in the political, social and technical ones. Without neglecting the contributions of other authors critical of the biomedical model of psychiatry, I will focus on the thoughts of three of the most renowned, David Ingleby, Germán Berrios and Allen Frances, and then compare them with those of Szasz and reach some conclusions. I have chosen these authors because, like Szasz, they are professionals and intellectuals of recognized prestige, all of them emeritus professors, and the works that I will discuss here represent a compendium of their thought and a magnificent outline of the positions that, with different nuances, every critic of biological psychiatry holds.

Ingleby coined the term "critical psychiatry" and made an accurate critical analysis of psychiatric positivism. Germán Berrios is undoubtedly the most recognized and respected author worldwide in the epistemology of psychiatry. For his part, Allen Frances was director of the diagnostic committee of the *American Psychiatric Association* (APA) and director of the *DSM IV* diagnostic manual, so his first-hand testimony on the diagnostic and pharmacological abuses of psychiatry is especially valuable. As with other critics, what sets them apart from Szasz is that they do not reject the concept of mental illness or promulgate the abolition of institutional psychiatry.

As I have noted, we owe the concept of "critical psychiatry" to Professor David Ingleby[143]who in 1980 edited the collective book *Critical Psychiatry. The Politics of Mental Health* (Ingleby (Ed.)k, 1982). While acknowledging his intellectual debt to the "anti-psychiatrists" (in his opinion, Laing, Cooper, Basaglia and Szasz), Ingleby pointed out the need for a new discourse critical of psychiatry since in the 1980s the political and social context was different from that of the 1960s:

> When anti-psychiatry was born [...] many believed that revolution was just around the corner. [...] The impression was given that capitalist society was falling apart on its own. However, [...] it was put back together again with remarkable speed. [...] The revolutionary euphoria quickly died down [...] [and] anti-psychiatry was abandoned [...] while orthodox psychiatry went on its way as if nothing had happened. [...] "Brain research" is everywhere proclaimed to be the key to progress, as if it had just been invented. [...] The anti-psychiatry of the 1960s seems to be a typical phenomenon of the time: the vagueness of its theories, its detachment from traditional politics and its contempt for the

[143]David Ingleby (United Kingdom, 1942) is Emeritus Professor of Cross-Cultural Psychology at the *University of Utrecht* (The Netherlands).

> strategy seems to have condemned it [...] to wither away as the good vibes faded. A much more practical approach is needed, both intellectually and politically, if the message of that movement is not to be entirely lost today (Ingleby, 1982a, pp. 9-11).

Although Ingleby joins the eternal common tendency to include Szasz among the anti-psychiatrists, I consider that he does not show any of the characteristics that he attributes to anti-psychiatry ("the vagueness of his theories, his detachment from traditional politics and his disregard for strategy"), but rather the opposite. As I have shown above, Szasz's theories and proposals are concrete and well-founded; he shows no detachment from traditional politics nor was he a "revolutionary" but, unlike other authors considered anti-psychiatrists, he was a radical advocate of individualism, capitalism and classical liberalism; and both his goal (abolishing institutional psychiatry) and his strategy (questioning the epistemological foundations of psychiatry and criticizing its coercive practices), while debatable, are clear from beginning to end. Finally, Szasz's voice did not disappear as did the "good vibes" of the British anti-psychiatrists of the 1960s, but remained loud, clear, and unchanged until it died out five decades later, in 2012. I submit that, contrary to their claim, Ingleby's words definitively prove that Szasz was never an anti-psychiatrist.

Ingleby states that "unlike David Cooper's 'non-psychiatrists,' all those who have contributed to this book [*Critical Psychiatry*][144]are of the opinion that the illnesses

[144]As can be seen in the credits of this book, the authors come from different fields: two psychologists (Ingleby and Treacher), three psychiatrists (Basaglia, Haugsgjerd and Kovel) and three sociologists (Conrad,

mental disorders exist [...] and, moreover, they demand specialized understanding and assistance" (Ingleby 1982a, p. 21). On the other hand, he states that critical psychiatry is an activity undertaken by those who set out to make "a good examination [of psychiatry], drawing on the clear insights that recent sociology and philosophy can offer it (*Ibid.*). This task, says Ingleby, is inherited from the critical theory of the Frankfurt School and, especially, from the writings of Jurgen Habermas (*Op.cit.* p. 22).

Twenty-five years after the publication of *Critical Psychiatry*, Ingleby (2005) points out that, from his point of view, this concept "does not mean anything other than what it indicates: any activity that refers to psychiatry from a critical point of view". He adds that no one should claim copyright to the term or to the activities associated with it, but that it should be recognized that, after some individual and ad hoc intervention in the 19th and early 20th centuries, what is now understood as critical psychiatry was generated in the 1960s around the anti-psychiatry movement whose "program" included:

1. Criticism of psychiatric power.
2. The rejection of the consideration of mental disorders as diseases and the questioning of the scientific basis for this belief.
3. The rejection of psychiatric diagnoses due to their labeling character.
4. Criticism of positivism and the commitment to a hermeneutic model of approaching madness that considers the human being as a subject and not as an object.
5. Psychopathology should be understood as an intelligible human reaction, a reaction to certain personal and social contexts (*Op.cit.*).

Baruch and Turkle). Of these, six are university professors and two work as psychiatrists (Basaglia and Haugsgjerd).

In a similarly titled collective book, *Critical Psychiatry. The Limits of Madness* (Double (Ed.), 2006), Ingleby notes that the book he edited in 1980 was the first to employ the term "critical psychiatry," understood as "a diffuse set, a loose coalition of thinkers and participants whose ideas show certain similarities, but who are not united by a common doctrine or plan" (Ingleby, 2006, p. 62). Heirs to the critical psychiatry of the 1980s, a group of psychiatrists working in the British *National Health Service* created in 1999 *The Critical Psychiatry Network*[145] (hereafter CPN) in Bradford (UK) (Thomas, 2013). Its founders and most active members are Joanna Moncrieff, Duncan Double, Patrick Bracken and Philip Thomas. Another prominent member is Sami Timimi, who subsequently founded the *International Critical Psychiatry Network*[146] (ICPN) as a global network meeting place where those "interested in critical thinking and alternative approaches to psychiatry" can dialogue. The growing number of CPN and ICPN members have a clearly political vocation, with their proposals seeking to influence government policies that guide mental health systems. Thus, they constantly publish their ideas in blogs and websites (their own and others'), scientific publications, books, media, congresses, etc., and maintain close links with associations of users and affected/victims of psychiatry. Philip Thomas (2013) points out that CPN's interests are:

1. The problem diagnosis in psychiatry.
2. The problem of evidence-based medicine and, related to this, the link between the pharmaceutical industry and psychiatry.

[145]http://www.criticalpsychiatry.co.uk

[146]http://www.criticalpsychiatry.net

3. The central role of contexts and meanings in psychiatric theory and practice, and the role of the context in which the psychiatrist works.

4. The problems coercion in psychiatry.

5. The historical and philosophical bases of psychiatric knowledge and practice.

At an undetermined date, CPN published a text entitled *Critical Psychiatry* in which they reject the biomedical model applied in psychiatry and support a psychosocial model that takes into account the context of the "mentally ill". They criticize the dominance of neuroscience in psychiatry and the indiscriminate use of psychotropic drugs (*Critical Psychiatry Network*, n. d.). In December 2012, CPN published a statement of objectives among are: to influence the way psychiatry is understood and practiced and to replace the biological model in psychiatry with one that is more oriented to the social, economic and cultural context of the mentally ill (*Critical Psychiatry Network*, 2012). However, and despite criticizing the biomedical model, CPN members do not renounce their status as physicians: "For years we have argued that it is possible for us to work as physicians with those who experience 'madness' and severe suffering while respecting the complexity of such states" (Bracken and Thomas, 2009, p. 242); "As physicians, what is clear to us is that we do not suffer in two distinct ways: physically and mentally" (Bracken and Thomas, 2010, p. 222). In the same vein, on the front page of their website they note that CPN is "a network primarily for psychiatrists, psychiatrists-in-training, and medical students interested in psychiatry." The above serves as an example of what I consider, as I pointed out earlier, the greatest dilemma currently facing critical psychiatrists, namely, to defend that they work as physicians but that neither the basis of their discipline nor their object of intervention should participate in the biomedical model (unique in any branch of scientific medicine).

Finally, NPC members claim to be heirs to the theories of Ingleby, Foucault and Miller and Rose (cf. Bracken, 1995 and Thomas and Bracken, 2004). Like Ingleby, CPN members maintain an ambivalent position regarding what is commonly understood as anti-psychiatry. They argue that critical psychiatry "is not antipsychiatry. There are important differences between the anti-psychiatry of the 1960s and the critical psychiatry of today; there are also important points of convergence but nevertheless the two are quite different" (Thomas, 2013).

On the other hand, we find the term "new epistemology of psychiatry" in the title of the book by Professor Germán Berrios[147]*Towards a new epistemology of psychiatry* (2011). This work brings together the conclusions of the research work of numerous scholars who since the 1990s have gathered in Berrios' private library in Cambridge to participate "in the ongoing task of revolutionizing psychiatry. [...] [And] they shaped what is presented here as the new epistemology of psychiatry" (*Op.cit.*, p. xiv). These scholars represented by Berrios are grouped under the denomination of the *Cambridge Psychopathological School* whose principles and objectives are the following:

> According to the Cambridge Psychopathological School perspective, the conceptual revision psychiatry requires the following: a) that both epistemological and historical analysis go hand in hand; and b) that psychiatry's core issues be addressed first, e.g., what kind of discipline/activity should psychiatry be (or become) in order assist those suffering from mental illness? How much of the natural and human sciences does psychiatry need in order for its (hybrid) narratives to be relevant to the

[147]Germán E. Berrios (Tacna, Peru, 1940) is professor emeritus of Epistemology of Psychiatry at the *University of Cambridge* (UK).

> What kind of objects of study are (or should) mental illnesses?
>
> What image of the human being (philosophical anthropology) should psychiatry implement?
>
> How deeply do values, prescriptions and cultural norms penetrate into the "scientific" claims of psychiatry? To what degree is the efficiency and care function of psychiatry affected by the fact that it is also used as an instrument of social control? How degrading is it for psychiatry to have become a commercial object? (*Op.cit.,* p. XIII).

Regarding the "anti-psychiatry" (pioneers) of the 1960s, Berrios' opinion is that their main contribution was to claim a "sharp focus on ethical issues" (Berrios, 1984, p. 303) that captured the interest of psychiatrists in the philosophical and epistemological problems of their discipline (Cf. Luque and Villagrán, 2000, p. 67; Guimón, 2001, p. 53).

According to Berrios, the positivist belief in the biological origin of mental disorders and the consideration of these disorders as things has led to the neglect of the thinking and creativity necessary for clinical practice. A deep epistemological (historical-philosophical) analysis of psychiatry is urgently needed to reveal the reasons that have led it to this situation and to shed light on "the origins, legitimacy and scope of the language and activities of psychiatry. [...] For the epistemologist, nothing can be considered sacred, even the idea that psychiatry should be a branch of medicine" (Berrios, 2011, pp. XII-XIII). The work of Berrios and his colleagues can be summarized in the following points:

a) The epistemology of psychiatry explores the hidden conceptual structures that lend coherence and meaning to empirical research;

b) An important question in this regard is whether, in biological and cultural terms, mental disorders or mental symptoms should be considered as having come first;

c) Research into the cultural perspective suggests that mental symptoms seem to have both ontological and epistemological priority;

d) This finding clashes with the conventional biological view that diseases have ontological priority and mental symptoms are but secondary and mediated clinical expressions;

e) The Cambridge model of symptom-formation offers a solution to this aporia and shows how brain signals and personal, familial, social and cultural configurators interact within a dialogical context to give rise to the mental symptoms in their final form (Berrios, 2013, p. 45).

Finally, I consider important the book by Professor Allen Frances[148]*Are we all mentally ill? Manifesto against the abuses of psychiatry* (2014) as it represents an authoritative critical look at institutional psychiatry and its links with pharmaceutical companies that influence research, the invention and dissemination of false illnesses and the indiscriminate treatment with drugs of an increasing number of people. What is interesting about this paper is that its author was an active part of that system for many years. That is why Frances says that this book is "part *mea culpa*, part *j'accuse*, part *cri-du-coeur*" (*Op.cit.*, p. 17).

In 1998, the American psychiatrist Loren Mosser sent the then president of the *American Psychiatric Association*, Rodrigo Muñoz, a letter of resignation. This letter summarizes in a very clear and forceful way the main points that any critic of official biological psychiatry maintains:

[148]Allen Frances (New York, USA, 1942) is professor emeritus of psychiatry at *Duke University*. (Durham (NC), USA).

1. The servitude of psychiatry to pharmaceutical companies: "Psychiatry has been bought, almost totally, by pharmaceutical companies".

2. The prevailing positivism in psychiatry: "We no longer understand people by their social contexts, instead we realign the neurotransmitters of our patients. The problem is that it is very difficult to have a relationship with a neurotransmitter."

3. The training of future psychiatrists in a mechanistic model: "The only function [of many psychiatrists] will be that of prescription signers hidden behind the guise of healers".

4. The creation of false illnesses through the *DSM* diagnostic system. "The DSM IV is a story with which psychiatry pretends to be accepted by medicine. We all know that it is more a political document than a scientific one" (Mosser, 1998).

As can be seen from the above, the criticisms put forward by the pioneers of the sixties (as Ingleby says) coincide, with some nuances, with those of the participants in the 1980 book *Critical Psychiatry*, with those of CPN, with those of the proponents of the "new epistemology of psychiatry" and with those of many psychiatrists such as A. Frances and L. Mosser who, from their own experience, put forward their claims as individuals. As in the rest of the world, in Spain more and more professionals and researchers are joining this trend critical of scientistic psychiatry. The works of Rogelio Luque and José María Villagrán (2000), Héctor González and Marino Pérez (2008), Jose María Álvarez (2012) and Alberto Ortiz Lobo (2013), among others, should be highlighted.

In the previous two chapters I have outlined Szasz's political criticisms of psychiatry as a social institution so there is no need for me to dwell on them again here. In this chapter I will focus on the critique of the principles underpinning psychiatry as a science. I subdivide this critique into two major interests that are connected: on the one hand, the critique of positivism (biomedical model) in psychiatry and, on the other hand, the epistemological analysis of psychiatry and the conceptual analysis of its flagship, mental illness. It will be these issues that I will deal with more closely in this chapter, always in relation to Szasz's epistemological approaches to three fundamental questions posed above: What is mental illness, what kind of science is psychiatry, and can psychiatry follow a medical model?

As I have already mentioned, given the large number of books and articles that currently raise criticisms of the biomedical model of psychiatry, I will take as a reference for the critique of positivism David Ingleby's article "Understanding 'mental illness'" (Ingleby, 1982b); as a reference of the epistemological analysis of psychiatry the book by Germán Berrios *Towards a new epistemology of psychiatry* (Berrios, 2011); and as a reference of the critique of the alliance between official psychiatry and pharmaceutical companies that leads to the elaboration of diagnostic classifications and the promotion of pharmacological treatments, the book by Allen Frances *Are we all mentally ill?* (Frances, 2014). I consider these three authoritative authors representative of many others (all professionals, academics and prestigious researchers, many of them psychiatrists) of which I offer, below, a brief selection of books and articles that the interested reader can consult and whose complete reference will be found in the "Bibliography": Albee and Joffe (2004); Alvarez (2012); Angell (2004); Bentall (2011); Boorse (1975); Breggin (1993); Carlat (2010); Cosgrove and Krimsky (2012); Deacon (2013); Deacon and Baird (2009);

Engel (1977); Frances and Widiger (2012); Healy (2013); Kandel (1998 and 1999); Kendler. (2005); Kendler and Schaffner (2011); Kick (1999); Kirsch (2010); Lanteri-Laura (2000); Levant (2004); Miller (2010); Moncrieff (2013); Peele (1981); Perez Soto (2013); Phelan. (2005); Van Gerven and Cohen (2011); Whitaker (2010); Zachar (2001).

4.2. THE THEORIES OF THREE CRITICAL PSYCHIATRISTS

4.2.1. DAVID INGLEBY'S CRITIQUE OF PSYCHIATRIC POSITIVISM

In the article that opens his book *Critical Psychiatry*, "Understanding 'mental illness,'" Ingleby (1982b, pp. 25-78), differentiates two paradigms in the traditional psychiatric debate about "what kind of creatures people are and in what way we should observe and explain their good and bad behaviors," the positivist and the interpretive (*Op.cit.*, pp. 25-26). Ingleby criticizes the former and supports the latter. He considers that if we really want to understand "mental illness" we should get rid of the epistemological illusion promoted by biological psychiatry: the myth that sooner or later science will discover an organic factor that will settle the discussions about (1) the origin of psychic disorders, (2) the reality of mental illness and (3) the belonging of psychiatry to medical science (*Op.cit.*, p. 23).

Since its origin in the 19th century, psychiatry has desperately sought to belong to the natural sciences as a way of gaining authority as an impartial and objective science. Ingelby believes that such a strategy achieves only the opposite: it discredits psychiatry as a science. He deplores the fact that philosophy is underestimated by the

scientistic psychiatry and considers the prevalence of the empirical over the conceptual approach in psychiatric research a serious mistake (*Op.cit.*, p. 24): "A science whose conceptual foundations have not been properly thought out is doomed to crumble regardless of the volume of findings it accumulates on them" (*Op.cit.*, p. 25).

Ingelby criticizes what he calls "the myth of objectivity" of psychiatric positivism, which claims that its observations are objective and its theories are based on the determinism of the natural sciences (*Op.cit.*, p. 30), assertions that psychiatry has not been able to prove to date.

He considers that "the vision of psychiatry as 'value-free' [i.e., objective] is a pure concealment of the truth" (*Op.cit.*, p. 29). To demonstrate this, he recovers for the psychiatric context what the sociologist Harold Garfinkel (2006), father of ethnomethodology, called in 1967 "the etcetera problem": Any attempt to reduce subjective experience to a series of formal criteria or classifications irremediably collides with innumerable nuances ("etcetera") that make the objectification of such experience impossible (Ingleby, 1982b, p. 32). Psychiatrists have responded to this problem in three ways: 1) by recognizing it and appealing to the "clinical judgment" of the psychiatrist, a quality that is by no means a guarantee of objectivity nor the exclusive patrimony of psychiatrists; 2) by disguising it with psychiatric diagnoses based on opinions and beliefs and with psychological questionnaires that pretend to reach solid interpretations based on concrete questions in which the only possible answer never fits: "it depends"; and, 3) asserting, as do radical positivists such as psychologist Hans Eysenck, that concepts open to subjective interpretation such as those of "anger" or "happiness" are not appropriate for scientific research. These researchers substitute clinical judgment "by constructs

deliberately artificial such as the points a person obtains in a 'test' or by some physiological index such as skin behavior, blood pressure or electroencephalograms", thus pretending to make the object of the human sciences (the subject) equivalent to that of the natural sciences (matter). Ingelby considers that this last way of responding to the "etcetera problem" is like "trying to lift oneself off the ground by pulling on one's shoelaces" (*Op.cit.*, pp. 32-33).

On the other hand, this author draws on sociologist Jeff Coulter (1973) in asserting that, contrary to what positivist psychiatrists maintain, "attributions of madness are inescapably rooted in sound cultural understanding and to imagine that they could be rooted in something that transcends common sense - that is, in scientific, neutral authority - simply does not make sense" (Ingleby, 1982b, p. 34).

Thus, Ingelby makes two observations: 1) that descriptions of people's behavior and states of mind are always subjective; and 2) that judgments about insanity are culturally conditioned, so that no psychiatric diagnosis can be objective. Thus, Ingleby radically questions the belonging of psychiatry and psychology to the natural (objective) sciences since "unlike the physicist, the human scientist cannot observe the void: every scientific framework is a social situation and the scientist cannot avoid influencing it" (*Op.cit.*, pp. 34-37).

Along with the "myth of objectivity", another of the epistemological bases of positivist psychiatry is, according to Ingleby, the deterministic principle based on the assumption that "the laws governing human life are of the same nature as those governing nature" (*Op.cit.*, p. 37). This doctrine has two versions, the strong and the weak. The

The first is based on the disease or "defective machine" model and states that all mental illness is caused by a physiological disorder. The second attributes the cause of problems to psychic or environmental factors. Ingleby criticizes the traditional eclecticism of British clinicians who, self-proclaiming themselves "non-ideological", pretend to be equidistant between these two positions which, in his opinion, are nothing but "the two sides of the positivist coin" (*Op.cit.*, 38).

He considers that "it takes a great deal of faith" to continue believing in the validity and efficacy of the "strong" version of psychiatric positivism and of the three proofs that he usually puts forward as a guarantee that psychiatry researches and works in a rigorously scientific manner: genetic studies, neurobiological research and physical treatments (drugs, electroshocks, psychosurgery, etc.), in the best of cases, do not produce the promised results and, in the worst, cause serious side effects. In Ingleby's opinion, these supposed proofs of the organic origin of "mental illness" are nothing more than pure rhetoric, since they have failed to prove anything (*Op.cit.*, 38-41). The organic is one of many factors that can influence the complex human psychology, without being able to objectively measure or establish the weight of each one of them as a determinant of behavior. Neither genetic nor neuropsychiatric research (despite their multiple, varied and often mutually contradictory "discoveries") has yet yielded the results announced for decades. This eternal etiological problem is referred to by Ingleby as the "'So what?'; for this is the only appropriate response to the numerous findings involving physiological or genetic factors in human behavior" (*Op.cit.*, p. 43).

On the other hand, positivism presents its "weak" version in the environmentalist approaches which, under another guise, are based on the same ideals of objectivity as the organicists:

> By asserting that a state of mind is *determined by* a particular environment [...] they imply that the person who has it in essence is not a rational agent. Their claims refer to "what drives people to do things" rather than "what people do," the important point being that, typically, we speak of being made to do something when we intend to excuse behavior for which we do not want to take responsibility. [...] An agent's situation provides the *bases* or *reasons* for his or her actions rather than providing the *causes*. The distinction is crucial because, while human behavior is truly orderly (for the most part), the "laws" beneath it are not of the same logical kind as the laws governing the motion of physical objects: they go hand in hand with agency and ultimately the laws themselves, unlike the laws of nature, are *artificial*, i.e., human-made. [...] Positivist explanations essentially rule out agency (*Op.cit.*, pp. 46-47).

As an alternative to positivism, says Ingleby, there is the interpretive paradigm of psychiatry which, instead of accepting the assumption that human reality follows the same laws as nature as a whole, considers that there is at least one distinctive feature that cannot be objectified because it is the very mark of subjectivity: "the capacity for meaningful behavior or 'praxis'". Unlike the positivist approach that focuses on locating causes, these common sense approaches seek to understand the reasons that drive each individual's desire and attempt to analyze the motives and ways in which the person lives his or her life. In short, they do not seek to catalog behavior but to explain it. Positivism, on the other hand, is a more solid paradigm that only presents

The interpretative approach, the strong and the weak version, admits different variants that differ from each other in their mode of interpretation. These can be grouped into two main approaches: the normalizing and the psychoanalytic.

It takes as representative of the normalizing approaches the theories of British anti-psychiatrists (Laing and Cooper) according to which insanity implies an intelligible behavior if the oppressive family and social context in which it appears is taken into account. Thus, "sick" behavior is considered both as a form of protest and as a mode of self-healing. For anti-psychiatrists, the schizophrenic is a cultural hero and a political dissident whom the system tries to corner. Ingleby believes that these approaches fail, as do the positivists, because they truly believe in healing (homeostasis) and in the possibility of fully explaining the process of madness. This optimism leads them to disregard something fundamental not only in madness but in the common experience of psychic conflict: the compulsion to repetition, "a residue that is refractory to all normal procedures of understanding and empathy" (*Op.cit.*, p. 72).

Ingelby considers that in order to address madness we must transcend both positivism and normalizing approaches and work within the framework of what he calls "deep hermeneutics" in which the psychoanalytic approach is oriented. According to this perspective, and in contrast to what anti-psychiatric phenomenology proposes, the human being is a being "fragmented, self-contradictory and alienated from his own experience", that is, someone who does not know about himself (*Op.cit.*, 73). But, at the same time, it is only the person as an agent (even ignorant of his own unconscious whose function is prescriptive and is expressed in a compulsive act that is not apprehensible by common sense or by any mechanistic explanation), who can interpret or give meaning to his existence. Even if the subject does not

The fact that the psychoanalyst is "master of his acts" does not mean that he is not a moral agent and, therefore, that such acts potentially possess a logic and an individual meaning. It is this ethical conception that emphasizes the agent that distinguishes psychoanalysis from normalizing theories whose foundation seems similar to the positivist one, since they place the origin of behavior and distress outside the subject. For Ingleby, it is the concept of compulsion that would allow the proper use of the term "illness" in the absence of organic pathology (*Op.cit.*, 73-78).

4.2.2. THE EPISTEMOLOGY OF PSYCHIATRY ACCORDING TO GERMÁN BERRIOS

Germán Berrios points out that, during the 19th century, alienism (later psychiatry) borrowed from medicine the anatomical-clinical model of illness. Since then, it has been considered that the description and classification of mental disorder should be made in neurobiological terms, an ideal that today has reached an absolutist turn to the detriment of psychosocial approaches (Berrios, 2011, p. 117). It was considered causal, in medical terms, any supposed link observed by contiguity between a behavior and a certain manifestation in the body: the abnormal behavior was caused by a brain lesion or dysfunction (*Op.cit.*, p. 19; Berrios and Marková 2002, p. 636). This belief meant that, in psychiatry, the natural sciences prevailed. However, Berrios considers that the relationship is just the opposite: "it is the human sciences that *configure* the object of psychiatric research". Under this primacy of the humanities, the function of the natural sciences will be to try to find links between semantic configurations (causes) and their effects on the body (consequences). The brain recordings associated with certain behaviors are incapable of defining mental disorder on their own. A clear example of this

is homosexuality, which was considered a disease of organic origin until the 1970s. The absence of evidence shows that the decision to include homosexuality in the catalog of mental illnesses was based on moral and not scientific arguments. The announcement of the discovery of a brain record supposedly associated with any mental disorder has always diverted attention from the fact that, in its origin, the decision to investigate and treat such a disorder was a social one. Berrios insists on the need not to lose sight of the correct epistemological sequence: in psychiatry, first the humanities and then the natural sciences (Berrios, 2011, p. 32).

Although in psychiatry it has been taken for granted that mental symptoms were caused by brain injury, such a belief was and remains speculative. Therefore, "considering that almost nothing is known about the causes of mental disorders, the idea that it is possible to create evaluation systems based on speculative etiologies is absurd, dangerous and unethical" (*Op.cit.*, pp. 308). Berrios qualifies the supposed causal link between the brain and the behavioral symptom as "parasitic dependence", an epistemologically erroneous link that has had several negative consequences such as, for example, the failure to contemplate the influence of social and cultural representations in the construction of mental symptoms, which makes it difficult to understand their formation process (*Op.cit.*, p. 155).

If the naturalistic view on the origin of mental disorders maintains today, after a brief interval in which the psychoanalytic view predominated (1950s-1970s), a clear position of advantage, it is because:

> The consequences deriving from its acceptance fit very well with the reification needs of neocapitalism. For example, holding that the psychiatric object is a "biological thing" allows: 1) its definition to be complete in terms of "brain pathology"; 2) its boundary definition (i.e., phenotype) to be regarded as scientific and value-neutral, rather than as a human choice; 3) its meaning and symbolism to be regarded as "epiphenomenal" and thus not primary therapeutic "targets"; 4) that the clinician be conceived as an "objective" amanuensis, as a scientist who observes and records facts, and not as the member of a dialogical exchange with the patient; 5) that clinicians offer society (including health insurance companies and the pharmaceutical industry) well-defined categories and rules for deciding what is wrong, what is nonsensical, where to invest, what to pay, etc.6) to have a classification of such objects in terms of the same taxonomic rules that govern biological classifications (which, for the time being, consist of speculative evolutionary neuroscience); and 7) that psychiatry can enjoy the prestige and power of neuroscience (*Op.cit.*, pp. 199-200).

However, Berrios reiterates, despite the fact that "the application of the so-called 'medical model' to psychiatry is analogical and supported by hypothetical conditionals", it is taken for granted that neuroimaging techniques will illuminate the cerebral origin of mental disorders (*Op.cit.*, pp. 72-73). This hypothesis is unfounded since:

> As unstable entities, and as constructs with poorly defined boundaries, whose determination depends on high levels of interpretation, SM [mental symptoms] are different types of data compared to, for example, blood flow indices, neurotransmitter concentrations or changes in contrast density. [...] We should ask ourselves whether it even makes sense to try to correlate SMs (or some SMs) with a specific brain activity (*Op.cit.*, pp. 174-175).

One of the negative consequences of the supremacy of the biomedical model of mental disorders is (along with the creation of unscientific diagnostic manuals and the indiscriminate treatment of disorders with drugs) the promotion of positivism in the form of so-called "evidence-based psychiatry" (EBP) in which psychiatrists are indoctrinated to believe that their practice is guided by mathematical demonstration. The immediate consequence of this belief is "the total reification of the doctor-patient relationship," such that any improvement will be attributed to medication and not to the expertise of the therapist. Berrios rules that the seemingly well-intentioned concept of evidence-based psychiatry "is a trust-destroying gimmick that needs some opposition [...]. The damage this has done to the practice of psychiatry in the 'developed' world may be irreparable" (*Op.cit.*, pp. 308-310).

He considers that, "given that mental symptoms are ontologically and epistemologically different from physical symptoms and signs" because they are constructed according to moral, social and aesthetic criteria, it is naive to believe both that biological psychiatry is a scientific activity without ideological foundations and that empirical research can locate the origin of symptoms with the same methods used in medicine (*Op.cit.*, pp. 242 and 25). Thus, against the biologicist belief in the cerebral etiology of mental disorders, Berrios argues that "the existence of a direct relationship between neurobiological references and mental symptoms (subjective affections) is unlikely" (Op.cit., p. 242 and 25). (*Op.cit.*, p. 192).

According to Berrios, there is a great conceptual distance between the supposed brain register and symptomatic behavior, a gap that neuroscientists ignore, dazzled by the supposedly significant correlations between the two but, in reality, of dubious validity.

(Marková and Berrios, 2009, pp. 348-349). But, on the other hand, being aware of this distance should not lead us to affirm, as the proponents of the psychosocial approach do, that the brain has no influence on behaviors. Berrios proposes "an intermediate solution, represented by the notion of hybrid object: mental symptoms arise from complex interactions between brain signals and 'semantic' information" (Berrios, 2011, pp. 203-204). For Berrios mental symptoms are:

> Oral acts that transmit reconstructed subjective affections. [...] The process of mental symptom formation begins with a brain region expressing its distress in a signal that reaches the subject's consciousness. The experience is pre-linguistic and pre-conceptual in the sense that it cannot be put into words (it may not be clear whether it is an image, a thought, an emotion, etc.). We have called this formless experience "primordial broth" (PC) to emphasize its inchoate nature and overt immediacy. The awareness of this proto-experience may affect the individual in different ways, causing bewilderment, fear, etc. The subject has to manage this experience and responses vary from ignoring it, to contemplating it, to needing to communicate it. In the latter case, the individual must transform an ineffable experience into an effable one (*Op.cit.*, p. 190).

Mental symptoms are "empty oral acts", in the sense that they do not convey information about their supposed brain origin (*Op.cit.*, p. 191). They are "hybrid objects [that] have a biological and a semantic component." Since the semantic component is the only one that conveys information, it predominates over the biological one and it is with respect to it that the clinician must orient his practice and the researcher his efforts to understand it (pp. 207- 208): "Mental symptoms (psychiatric objects) cannot be explained by means of

no intrinsic neurobiological structure, but by the semantic and symbolic envelope that gives them a particular communicative value" (*Op.cit.*, p. 201).

The model proposed by the *Cambridge School* is called "descriptive psychopathology" and results from a combination of the epistemology of the natural and social sciences (*Op.cit.*, p. 147).

> The disciplines involved in the natural and human sciences are called hybrid disciplines, and their conceptual status tends to be confused. Psychiatry is a typical example because "madness" (or mental disorder, whatever name is given to its object of study) is not found as an object in nature (like gold or horses), which has somehow preceded the arrival of the human race. Madness is something whose very existence (construction) depends on prescriptions and decisions, which are NOT part of the physical world. Indeed, its existence depends on certain social agents who decide that the behavior of some other human beings "has a disorder". Of course, once such a decision is made, experts in the brain representation human behaviors will (as expected) move on and discover that such behaviors do indeed have brain records. The order of events, i.e., the fact that the biological follows the conceptual, tends to be hidden from view. This concealment has encouraged the "naturalization" of mental disorder, namely, the claim that mental disorder is not the description or meaning of the disturbed behavior, but in fact its brain record *(simpliciter)*. This is as fallacious as reducing the beauty of a classical painting to a particular distribution of pigments and materials space (*Op.cit.*, pp. 28-29).

"According to the Cambridge model, mental symptoms are brain signals configured by cultural codes" (*Op.cit.*, p. 244). That is to say, contrary to what is postulated by the

the biomedical model of psychiatry, it is the cultural component that shapes the brain signal. Therefore,

> If subjective mental symptoms are individual interpretations of (usually blurred) personal experiences, then such mental symptoms are indeed *personal constructs.* They are constructs in that subjects create meaning or construct meaning from rather inchoative pre-linguistic experiences. They *are personal in* that, although social and cultural influences will help determine the specific way in which the subject makes sense of and expresses the experience, the experience itself is unique or personal to the subject and is inaccessible to all others. In this sense, subjective SM [mental symptoms] are *sui generis,* since there is no external verification for their "existence" (*Op.cit.*, pp. 167).

The following quote summarizes the epistemological position of the *Cambridge School* well

intermediate in the biological-social continuum:

> Current emphasis on empirical research in psychiatry has led to some neglect of the conceptual problems that are integral to the discipline and its subject matter. Psychiatry is a hybrid discipline the work of which is rooted in both the natural and the human/social sciences. Psychiatry's objects of inquiry, that is, mental symptoms and mental disorders, are likewise hybrid objects whose constituents originate from both knowledge sources to form biological-semantic complexes of variable stability. Taking a relational epistemological stance is essential in order to try to clarify such structures and to determine the relative contributions of biological and semantic (social, cultural, individual, etc.) components to them (Marková & Berrios, 2012, p. 226).[149]

[149]See also Berrios 2015, pp. 44-45.

In short, Berrios argues that psychiatric symptoms are hybrid objects composed of a biological and a semantic component. Since the semantic component prevails as the only one with informative potential, biological research is unlikely to provide a valid explanation for the formation of mental symptoms. He considers more appropriate a hermeneutic approach that allows understanding the symptoms by analyzing "the semantic component in terms of its history and *sui generis* nature. In other words, hybrid objects must be understood, rather than explained" (Berrios, 2011, p. 211).

In clinical practice it is observed that the subject is unaware of the meaning of the symptom manifested in his behaviors, thoughts or feelings. Therefore, the effort of understanding should be directed to the subject and not so much to the symptom. Since the personal and social contexts are different in each subject, it is the subject who must find the meaning and make sense of the symptom individually, even though it may resemble that of other people (*Op.cit.*, p. 173).

> This means that understanding, rather than explanation, may be the best method of accessing them epistemologically. In this sense, hybrid objects [mental symptoms] are closer to abstract objects than to physical ones. Although theoretically accessible through explanations and understanding, I believe that the latter approach is more likely to be successful and that researchers should make certain efforts in order to develop a hermeneutic method that is more or less specific to mental symptoms (*Op.cit.*, p. 210).

4.2.3. FRENCH ALLEN'S JUDGMENT OF THE PSYCHIATRIC DIAGNOSTIC SYSTEM AND PHARMACOLOGICAL TREATMENT

Allen Frances was director of the diagnostic committee of the *American Psychiatric Association* (APA) and director of the *DSM IV* diagnostic manual. In 2013, at the age of 71 and already retired, he published the book to which I will refer here *Are we all mentally ill? A Manifesto Against the Abuses of Psychiatry* (2014), a title that does not correspond to the original: *Saving Normal. An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*. As Frances states in the foreword, she began to consider the ideas set out in this book in 2009 because of her concern about the imminent publication of *DSM 5* (which was finally published in 2013) and its predictable negative consequences: diagnostic inflation and the mass prescription of psychotropic drugs to a greater number of people, including children. She started writing articles critical of that system, inaugurated two blogs on the psychologytoday.com website (*Saving Normal* and *DSM in Distress*, currently current) and also regularly publishes articles on the psychiatrictimes.com and hufftingtonpost.com websites and, on occasion, in many other places. The main message Frances conveys is that "DSM 5 takes psychiatric diagnosis in the wrong direction, will create new false epidemics, and encourages even more medication abuse."

In 1987, the APA appointed Frances to lead the working group that would draft the *DSM IV*. He acknowledges that, although it was not its objective, *DSM IV* contributed to the creation of a growing inflation of diagnoses whose main consequences were the psychiatrization of everyday problems, the emergence of false psychiatric "epidemics" (autism, attention deficit and bipolar disorder), and the fact that "we are becoming

becoming a society of pill addicts" as drug treatment is the method mostly employed to combat supposed "mental illnesses" (Frances, 2014, pp. 12-13).

He describes the disorders included in the *DSM* as "a kind of hodgepodge without internal coherence and not mutually exclusive" (*Op.cit.*, p. 38). However, "the DSM has achieved enormous social significance and determines all kinds of important practical things that have a great impact on people's lives, such as who is considered healthy and who is considered sick" (*Op.cit.*, p. 10).

According to Frances, "the decision about where to place the bar [of 'disease'] is always subjective". She recognizes and regrets the incompatibility between, on the one hand, a necessary raising of the threshold of severity and duration of disorders that would limit over-diagnosis and, on the other hand, the stability provided by having a diagnostic classification (*Op.cit.*, p. 45). However, Frances considers that, although the sense of mastery provided by a diagnosis is false, "it is better to have an inaccurate or incorrect name for a mental disorder than none at all" (*Op.cit.*, p. 57). Frances himself acknowledges that, unlike in the rest of medicine, the benefits gained from early diagnosis of mental disorders are small compared to the harm they do to a majority of patients (*Op.cit.*, p. 106) and that "since the appearance of *DSM III* in 1980, there has been no real diagnostic breakthrough and, since early 1990s, no breakthrough in treatment" (*Op.cit.*, p. 208).

It traces the history of the *DSM*, from Kraepelin's diagnostic classifications at the end of the 19th century, to the appearance of the *DSM I* devised by the U.S. Army (1952) and the *DSM II* (1952).

DSM II (1968) very little used manuals), the discrediting psychiatric diagnostic classification in the 1970s with the publication of articles such as Rosenhan's (1973) mentioned above and, finally, the resurgence of medical psychiatric taxonomy with the publication of *DSM III* (1980) promoted by the *American Psychiatric Association* and directed by Robert Spitzer, who undertook "an almost fanatical lifelong search for a systematic and reliable psychiatric diagnosis" (*op. cit. p. 85*). *cit.* p. 85). State funding for psychiatric research increased considerably and "pharmaceutical companies also began to invest large amounts of money in research as they rushed to develop profitable new psychiatric drugs" (*Op.cit.*, p. 86).

Frances states that, despite the powerful technology employed in neuropsychiatric research, there is no laboratory evidence of the biological origin of mental disorders. The diagnosis of such disorders is therefore based "on subjective judgments that are inherently fallible and subject to capricious changes" (*Op.cit.*, pp. 30-32). Thus, the method chosen by Spitzer to determine the mental disorders and symptoms to be included in the *DSM III*,

> was not a pretty sight; [...] experts shouting out what they considered to be the best symptoms, often loudly disagreeing with each other. Their passionate opinions were defended with the fierce determination born of experience, not of scientific data [...]. If there continued to be controversy, the loudest, the most self-confident, the most stubborn, the most senior, or the last one to talk to Bob [Spitzer] had the upper hand. It's a terrible way to develop a diagnostic system, subject to all sorts of biases, but it was the best way available at the time (*Op.cit.*, pp. 87-88).

The participants in this process were biologically oriented psychiatrists who wanted to bring psychiatry closer to medicine and away from the psychological and social realms. The result was a marked reductionism whose main consequence was a clear diagnostic inflation. Frances does not blame this on Spitzer and his colleagues but on the subsequent "commodification of diseases by pharmaceutical companies". In 1987 the *DSM IIIR*, the revision of its predecessor, was published, also led by Spitzer and which Frances considers "a mistake and a disaster" (*Op.cit.*, p. 92) since instead of limiting the ill-fated consequences of its predecessor, they enhanced them: "sales of Prozac [an antidepressant] soared, at least in part, because of the DSM's loose definition of major depressive disorder" (*Op.cit.*, p. 93). Frances knows what she is talking about because she was part of the group of experts who put together *DSM III* and *DSM IIIR*. In 1994, *DSM IV* was published, this time directed by Spitzer's successor, Allen Frances himself, who openly declares that "DSM IV was faithful to DSM IIIR" (*Op.cit.*, p. 97). The result was, in Frances' own opinion, very clear: in the shadow of *DSM IV*, diagnostic inflation and indiscriminate and lax pharmacological treatments continued to grow. Thus, "the pharmaceutical companies had won and [...] we [psychiatrists] had lost" (*Op.cit.*, p. 98). Frances regrets not "having done much more to sound the alarm bells. [...] I regret enormously that we had not tried harder" (*Op.cit.*, pp. 98- 99). He acknowledges that his manual directly fostered false epidemics: "We did nothing to prevent the over-diagnosis of yet another set of disorders invented by pharmaceutical companies [...] which has allowed the widespread and unconstitutional abuse of involuntary psychiatric hospitalizations" (*Op.cit.*, p. 99). He adds that "when the DSM IV was finished, I was quite satisfied. Now [twenty years later] I wish I had done more to save normal people and reduce the ease with which pharmaceutical companies were able to sell diseases" (*Op.cit.*, p. 99). He states that

56% of the experts involved in the *DSM IV* had relationships with pharmaceutical companies, but these had no influence on the drafting of the manual (*Op.cit.*, p. 100).

This is hard to believe, since Frances himself points out that infantile-juvenile diagnoses such as autism or attention deficit disorder are undergoing a dramatic inflation and that prevalence rates "have been generated by psychiatric epidemiologists, using an inherently erroneous and systematically biased method to diagnose non-existent disorders. How is it possible that an entire scientific field has become so perverted? It is all due to economic considerations" (*Op.cit.*, p. 112). Finally, Frances sentences:

> DSM 5 lists conditions that will undoubtedly become fashionable in the future. All of them present symptoms that are part of everyday life and are common among the general population. None of them has a definition precise enough to prevent misclassification of many people currently considered normal. None has a treatment with proven efficacy. All of them are likely to involve unnecessary and sometimes harmful treatments or tests. The consequences of this will be overdiagnosis, unnecessary social blight, overtreatment, inappropriate allocation of resources, and a negative impact on our self-image as individuals and as a society (*Op.cit.*, p. 212).
>
> Since there are no biological tests or clear definitions distinguishing normality from mental disorders, psychiatric diagnosis depends on easily influenced subjective judgments. Whenever there is a large increase in a mental disorder, it is most likely a fad. Surely many, or most, of the new 'patients' are actually 'quite normal'. They have been misclassified and will probably be subjected to unnecessary treatment. Psychiatric fads arise when a powerful authority gives them force and legitimacy. The DSM system and the

> 'experts' who created it [as himself] have been the ones who have made it fashionable; they are the driving force that has led to the identification of new mental disorders [...] Experts true believers who really love their diagnoses and want to see them grow. [...] In the thirty-five years I have spent rubbing shoulders with experts, not once has anyone suggested raising the bar to reduce the scope of their area of expertise (*Op.cit.*, pp. 109-110).

Having said that, he states, "Obviously, the major promoter of recent fads has been the marketing of the pharmaceutical industry" (*Op.cit.*, p. 111); and: "DSM IV played a secondary role in the steady advance of diagnostic inflation. The primary driver was the marketing of the pharmaceutical industry" (*Op.cit.*, p. 202). In other words, psychiatrists create, support and promote the new diagnoses, but it is the pharmaceutical companies that are responsible for this. The most elementary logic allows us to deduce that if psychiatrists had not given such names and such low thresholds, the pharmaceutical companies would not have sold so many drugs prescribed, of course, by physicians: "80% of prescriptions [for psychotropic drugs] are issued by primary care physicians with little training in their correct use, strongly pressured by the pharmaceutical companies' salesmen and by deceived patients, after hasty visits lasting seven minutes and without any systematic control" (*Op.cit.*, p. 14). Although it is presumably the doctor who ultimately has the last word in prescribing, Frances insists that "the fault lies primarily with the system, not with the doctor" (*Op.cit.*, p. 132).

Finally, Frances traces the history of psychotropic drugs (which he himself admits to prescribing) from the opiates and barbiturates used in the first half of the 20th century and the antipsychotics, lithium and antidepressants used later, whose side effects were devastating, to the revolution that began in the 1990s, which led to the development of a new generation of psychotropic drugs.

The 1970s with a new generation of psychotropic drugs (such as Valium) with apparently less serious side effects but with a strong addictive capacity. Their use became enormously popular, they began to be prescribed indiscriminately by primary care physicians and the pharmaceutical companies realized that they had found El Dorado. The late 1980s saw the emergence of SSRI antidepressants, whose main exponent, Prozac, and its substitutes became an absolute bestseller. The 1990s saw the birth of the latest generation of atypical antipsychotics (e.g. Risperdal) which followed the same successful path as they were (and are) prescribed everywhere. He acknowledges that research on the drugs:

> They are run by market geniuses, not by scientists, and the result is easy to predict: big sales and lousy discoveries. [...] Researchers are corrupt, and sometimes scientific articles are written by corporate spin doctors. [Pharmaceutical research is a deceitful scam that seeks to seduce and mislead rather than enlighten physicians and the public [...]. The pharmaceutical industry has not created a single product whose efficacy is superior to that of drugs available sixty years earlier. [...] [But, evidently,] sixty million dollars a year is very useful for selling products and buying politicians. [...] A huge legion of psychiatric "opinion leaders" are recruited to trumpet the wonderful benefits the drugs provide and downplay the harms they cause. [...] I know the "opinion leaders" firsthand because I was one of them (*Op.cit.*, pp. 118-122).

While Frances' criticism of the *DSM* and the pharmaceutical companies is admirable, it would have been desirable that he had exposed it when he was part of, and therefore promoted, this perverse network. Now, Frances lectures and interviews all over the world and is hailed as the liberator of psychiatry. On the cover of the Spanish edition of his

book to which I have referred here he is defined as "the most outstanding psychiatrist of the moment" (Cf. Frances, 2014).

4.3. SZASZ Y THE PSYCHIATRISTS CRITICAL PSYCHIATRISTS. A BRIEF COMPARATIVE STUDY

Having discussed Szasz's theories in the second chapter and those of the current critical psychiatrists in this chapter, my intention in this last section is to compare the two in order to clarify whether the latter may have an antecedent in the former or, more specifically, whether Szasz should be considered a precursor of the critical psychiatrists. To accomplish this task, I will first summarize the fundamental presuppositions of biological psychiatry and then compare the positions of critical psychiatry with those of Szasz.[150]In order to provide a general outline of each position, in this brief comparative study I will not dwell on the details but will outline the points of overlap between Szasz and the current critics of psychiatry. I trust that the attentive reader will be able to find the detailed information in the preceding pages. Moreover, I will only address the philosophical and practical aspects of psychiatry (and not the political issues) in relation to the three fundamental questions raised in this research: what is mental illness (conceptual analysis), what kind of science is psychiatry (epistemological analysis), and can psychiatry follow a medical model (analysis of consequences).

[150]I will compile a brief selection of quotations (literal and paraphrased) of Szasz from the period 1956-1965 presented in the second chapter, "System of Thought". For ease of reading, I will use only the Spanish translations, although I will give the page of the original English editions when appropriate.

Critical psychiatrists only mention Szasz in passing when they do not reject him. However, although they claim that they have nothing to do with Szasz, these authors usually refer to with respect and admiration. This is the case, for example, with Germán Berrios who does not cite Szasz in any of the writings I have consulted. In a personal communication, Professor Berrios informs me that "Thomas and I never identified points of contact between our thought, epistemology, ontology, politics or vision of medicine. My thinking is essentially historicist, constructionist, anti-progressive, anti-reductionist, narrative and relativistic; Thomas's was *exactly the opposite*. Nevertheless, we were friends for years, and to him I dedicated the acceptance lecture for one of my *honorary* doctorates" (my italics).[151]

For his part, Allen Frances only mentions Szasz in "Acknowledgements" section of the book I have summarized above: "Despite *strongly disagreeing* with the extremist positions of the recently departed Tom Szasz, I felt for him a great personal affection and always admired his willingness to fight for what he considered just, regardless of the sacrifices involved" (Frances, 2014, pp. 327-328, my italics).

In this section I would like to check whether the thinking of Frances and Berrios, among other critical psychiatrists, is *exactly the opposite* of that of Szasz and whether, therefore, these authors are *in total disagreement* with him or whether they are only partially in disagreement with him and, if so, what such disagreement consists of.

[151]Personal communication of April 23, 2015 reproduced with permission of the author. The doctorate referred to by Professor Berrios was awarded to him at the *National University of Córdoba* (Argentina), on September 12, 2012 (four days after Szasz's death).

Ingleby and members of the *Critical Psychiatry Network* do name Szasz more frequently and recognize his value as a critic. However, they consider his way of understanding the experience of madness to be simplistic, a criticism to which I join as I will argue in the next chapter.

In any case, there is no criticism of Szasz as harsh and disparaging as those expressed by defenders of official psychiatry, such as Harvard University psychiatry professor and forensic psychiatry expert Thomas G. Gutheil: "Szasz's theories about the mythical nature of mental illness have been rendered obsolete by genetic studies, imaging techniques, cross-cultural anthropology and so on. [...] I can't find a single reason that would make him worthy of a book like this [*Szasz under fire*]. [...] Simply put, Dr. Szasz is no longer worth the trouble" (Schaler (Ed.), 2005, pp. XXIII-XXIV). One of the main intentions of this thesis is to demonstrate the opposite, i.e., that Szasz was and remains a theorist to be reckoned with.

Epistemological and conceptual presuppositions of biological psychiatry.

The advocates of the so-called biomedical model of psychiatry consider that mental illness has a genetic and/or cerebral organic origin. What we call "mind" is nothing but the result of a particular structure and functioning of the brain. The observation of this organ by means of imaging techniques and other tests makes it possible to locate the mental illness as any other physical illness. In this way, a clear difference can be objectively established between a mentally healthy person and a mentally ill person. Thus, it is appropriate, from an epistemological point of view, to consider psychiatry as a medical specialty, i.e., as a

application of the natural sciences. Psychiatrists must therefore be trained and act like any other medical specialist.

Since psychiatry is concerned with the biological aspects that give rise to mental illness, the life history of patients is not particularly significant in the investigation, diagnosis and treatment of mental illness. Research follows a rigorously scientific method; diagnostic classifications are established on the basis of the data provided by such research and are statistically valid and reliable; and drugs or other physical methods are the best method for curing mental illness. This is how Richard Bentall, a psychologist critical of the biomedical model, explains it:

> Most people who want to work in psychiatry [...] follow a medical approach, in which social and psychological therapies, if they are ever used at all, are considered of lesser importance than pharmacological treatment, because they naively believe that this is the best way to help their patients.
>
> The main assumption behind this approach is that psychosis is a disease of the brain, an idea that has been prevalent in psychiatric circles for over a century and continues to be promulgated in manuals for future mental health professionals [...] and in advice given to patients and their caregivers by physicians, pharmaceutical companies, and various other organizations that insist, for example, that "schizophrenia is a treatable medical condition." The meaning of the patient's symptoms and the context in which they appear are therefore considered irrelevant, and the patient's efforts to talk about them and see if anyone will listen to his or her story are often dismissed (Bentall, 2011, pp. 62-63).

Comparison of the epistemological and conceptual assumptions of critical psychiatrists and Szasz.

As shown above, in *The Myth of Mental Illness* (1961) and in the essays that preceded it, Szasz already openly defended the need to reconsider the conceptual, historical, ethical, political and epistemological bases of psychiatry as proposed by current critical psychiatrists.

Both point out that, historically, the myths of objectivity and biological determinism of mental disorders have supported the consideration of psychiatry as a natural science, which has allowed psychiatrists to unduly share the prestige of neuroscientists. Psychiatrists themselves have been the creators of these myths and the first ones interested in keeping them alive. However, the emphasis placed by biological psychiatry on asserting itself as a medical discipline derives not from scientific criteria but from psychiatrists' desire for greater power and social recognition.

More than half a century ago Szasz pointed out that, motivated by the desire to be recognized as physicians, "psychiatrists [of the 19th century] began to call 'illness' (that is, of course 'mental illness') anything that would allow any sign of dysfunction to be detected on the basis of any kind of norm" (Szasz 1961b, p. 45; Transl.: 1999, pp. 97-98). The myth of mental illness became popular and was taken as a scientific truth despite the fact that there was no evidence for the organic etiology of "mental illness". Thus, "the prestige and power of psychiatrists increased as the domains within the sphere of their specific discipline were constantly widened" (*Op. cit.*, p. 43; Transl.: 1999, p. 96).

Similarly, critics emphasize that psychiatry was born in the 19th century with the argument of the existence of a causal connection between brain function or structure and behavior. Although such a relationship remains speculative, it has been taken as an unquestioned truth. The scientistic claims of psychiatry are pure rhetoric (Szasz insists on exactly the same thing). Both he and they advocate the need for a serious analysis of the conceptual and epistemological foundations of psychiatry before accepting such premises of biological psychiatry out of hand.

For Szasz and critical psychiatrists the first obligation of a scientist is to be honest with the real foundations of his science which, in the case of psychiatry, have very little to do with medicine and much to do with the human and social sciences. The tendency not to recognize the capabilities and limits of psychiatry by disguising it in medical garb damages its scientific integrity (Szasz, 1961a, p. 64 and 1957c, p. 447). Such an unexplicit desire to participate in the social recognition enjoyed by physicians seriously jeopardizes its meaning, its usefulness and even its very existence (Szasz 1961b, p. 4; Transl.: 1999, p. 43).

Szasz's conceptual premise, contrary to the thesis of official psychiatry (then and now), is that the term "mental illness" comes from a metaphorical identification of certain behavioral phenomena with the symptoms of brain diseases. He denounces this conceptual error and positivism and biomedical reductionism from which it derives, according to which: "All the problems of life are attributed to physical-chemical processes which medical research will discover in due course" (Szasz, 1960a, p. 113). Critical psychiatry is equally contrary to this assertion but, unlike Szasz, does not deny the existence of mental illness or disorder but does not consider it to be "a

disease like any other" and, therefore, questions the validity of the biomedical approach in its research and treatment.

Both critical psychiatrists and Szasz argue that psychiatry must stop imitating medicine and find its own identity as a science.

> In order to guarantee the scientific progress achieved in our field, I believe that we could do no better than to restructure our knowledge in a psychosocial, linguistic and ethical frame of reference. [The integrity of the sciences of the human being as a social being (and as an individual) requires, therefore, a sincere recognition of its historical origins and a rigorous evaluation of its particular characteristics and potentialities. Only in this way, and not by imitating the grandeur of the older and better established sciences, should the psychosocial disciplines claim their rightful place among the sciences (Szasz, 1961a, p. 65).

Such an end requires an honest and rigorous analysis of its object of research and intervention, human subjectivity, leading to the recognition of the scope and limits of the discipline. Such an analysis leads to conclusion that psychiatry does not belong, at least not completely, to the natural sciences. It could be said, in any case, that psychiatry is a hybrid science (Szasz does not contemplate this mixed possibility and considers psychiatry a social science). Certainly, say the critics, there are brain records associated with mental disorders, but they cannot be taken as proof nor as a causal explanation of the exclusively biological origin of mental disorders, but only as an empirical finding. Mental symptoms are different from physical symptoms since they are personal constructs. The origin and structure of mental symptoms remain elusive and are likely to remain so since the only information that can be provided is that of the physical symptoms.

The significant meaning comes from the patient's account and not from his or her brain records. It is the person himself, therefore, who gives them a strictly individual meaning. Therefore, although there is a biological component to mental symptoms, the clinician can only guide his practice with respect to its other component, the semantic. Thus, both psychiatric theory and practice must give prevalence to language and the social context and not to the organic, as biological psychiatry maintains.

Critical psychiatrists denounce that psychiatry's diagnostic systems are based on capricious political and personal criteria far removed from any scientific rigor. Szasz criticizes the tendency institutional psychiatry to deny the moral aspects of its practice and to assert, correspondingly, that its judgments are medical and free of personal values (Szasz, 1960a, p. 116). If the psychiatric diagnostic system does not work (does not satisfy all clinicians) it is because it rests on precarious foundations (Szasz 1961b, pp. 172- 173), since it purports to classify, as if they were natural entities, matters relating to how people live and how they relate to others. Psychiatry seeks to construct a psychopathological system based on medicine to categorize ethical issues (Szasz, 1957d, 405-406). Thus, Szasz considers that psychiatric diagnoses have no justification from a scientific point of view. They are judgments formulated by the psychiatrist about the patient's behavior and not medical syndromes as they are usually presented in psychiatric writings (Szasz 1956a, p. 442). Finally, he criticizes the use of psychiatric diagnoses as nouns that claim to explain everything but fail to explain anything (Szasz, 1957d, 409-410).

Since they consider themselves physicians, the first therapeutic resource employed by biological psychiatrists is psychotropic drugs. Today, numerous researchers have

incontrovertibly proved the corruption underlying the links between official psychiatry and pharmaceutical companies, leading to a progressive diagnostic inflation and a massive consumption of drugs that not only have not demonstrated the promised efficacy but often cause numerous and serious side effects. In 1957 Szasz already warned of the social and personal consequences of the prescription of psychotropic drugs (antipsychotics) which he called "chemical straitjackets": "The widespread acceptance and use of so-called tranquilizing drugs constitutes one of the most remarkable developments in the recent history of psychiatry. [...] These drugs function, in essence, as chemical straitjackets" (Szasz, 1957a, p. 91). For Szasz it is absurd, from a logical point of view, to expect drugs to solve the very problems of human life that psychiatrists call mental illness (Szasz, 1960a, p. 115).

Critical psychiatrists denounce that more and more of the population is being diagnosed and treated with drugs unnecessarily and, in this process, the relationship between the clinician and the patient, the true driving force of therapy, loses strength as a determining factor of improvement in favor of the apparent effectiveness of the drugs. Thus, say Szasz and critical psychiatrists, the psychiatrist tends to become a mere diagnostician and administrator of drugs and the patient the bearer of a defective object, the symptom, which must be located and repaired. In this process the value of the person as an agent remains in the background.

For critics, the psychiatric symptom, unlike the medical symptom, cannot be isolated from the rest of the patient's existence and history. The psychiatric symptom speaks for the patient, it is the representative of his subjectivity. Similarly, for Szasz "in the symbolism of his symptom the patient presents [...] the whole history and structure of his

neurosis' [...]. In order to understand the 'symptom' of the latter we must know all the historically singular characteristics of the social circumstances and the development of his personality" (Szasz 1961b, p. 136; trans.: 1999, p. 221). However, it is not possible to fully express a sensation, an emotion or a psychic symptom in a discursive language (*Op. cit.*, p. 138; Trans.: 1999, p. 224).

In contrast to the medical model of intervention, critical psychiatry advocates an approach to psychiatric practice where understanding individual behavior prevails over description and statistics. "The physician's task [says Szasz] requires him to deal with the physical and the causal, and to treat the patient, at least in part, as an object. The psychiatrist's task requires him to deal with the psychological and the existential, and to treat the client as a person" (Szasz, 1965a, p. 37-38; Transl.: 1971, p. 58). This perspective requires the psychiatric professional to be cultured, i.e., to have a multidisciplinary training in which the humanities play an important role. Szasz advocates an open and non-exclusionary approach that "achieves a much needed and long overdue rapprochement between psychiatry, on the one hand, and philosophy and ethics, on the other. [...] Psychiatrists cannot expect the possibility of solving ethical problems by methods corresponding to the field of medicine to be fulfilled" (Szasz, 1961b, p. 8; trans.: 1999, pp. 48-49). Fifty years later, Berrios states that "for practicing psychiatrists, it is best to be trained in philosophy and epistemology" (2011, p. 35).

I trust that this brief selection of quotations has been able to demonstrate that many of the proposals of today's critical psychiatry were formulated by Szasz many decades earlier. In the next chapter I will present some reasons why, in my opinion, critical psychiatrists neither take Szasz into account nor recognize him (unfairly) as their precursor.

5. SZASZ'S FUNDAMENTAL ERRORS, A PERSONAL OPINION AND A PROPOSAL

5.1. A THEORETICAL ERROR: TRIVIALIZING PSYCHOSIS

According to Szasz, all behavior is determined almost exclusively by cultural factors. Paradoxically, as with the biological model of mental illness that Szasz criticizes, his model of "problems in life" is *Procussian*: every case must fit within the limits of the pre-existing framework (biologicist and culturalist, respectively), without exceptions or nuances. Obviously, this has consequences for the way psychiatry is understood and practiced , from this rigid perspective, aspects of human psychology are disregarded which, depending on the circumstances of each individual and after due analysis of the facts, prove to be as determinant as they are irreducible and incomprehensible.[152]Accepting such characteristics implies, far from any conformism, an assumption of both the conjunctural possibilities and structural impossibilities of each subject, which allows for a more pragmatic and, possibly, more useful approach to clinical work.

Just as there is no conclusive scientific proof of the exclusive organic determination of psychological disorders, neither can it be confirmed that biological factors have no influence whatsoever. Probably due to the extremism of both positions, the so-called bio-psycho-social model, which integrates the three possible variables (body-mind-society) interrelated in all subjectivity has recently gained strength,

[152]See, in the previous chapter, the Freudian concept of "compulsion" formulated by Ingleby.

depending on each individual case, may have a different specific influence on the origin of the disorders and their behavioral effects. This model, which fits with the propositions of critical psychiatrists, instead of starting from a belief constituted as truth, arises from a *skeptical agnosticism* whereby any circumstance and possibility is considered as plausible in each individual case.

In relation to the above, in this epigraph I would like to dwell on a circumstance that I consider deserves to be highlighted and taken into account. The issue could be formulated with these two questions: what was Szasz's relationship with psychotics (also called seriously mentally ill) and what is the relationship between his liberal ideology and his consideration of psychosis not as a psychiatric disorder but as a result of certain personal choices which he calls problems in life? What will be discussed here is the question of self-control and personal responsibility of the so-called "mentally ill".

In 1995, at the age of 75 and five years after his retirement from the university, Szasz stopped working as a private psychotherapist, an activity he started in 1948. Shortly afterwards, in an interview, his interlocutor asks him "How did you cope with patients with severe mental disorders?" (Kerr, 1997, p. 43). Szasz answers:

> After I came to Syracuse in 1956, my private practice was always less than half time. Because of the way I worked, the problem you pose did not arise. Anyone who wanted to see me as a patient had to make his own appointment and had to pay me, directly. This excluded persons who did not really want to see a psychiatrist but were forced to do so by others, especially by legal coercion. My practice was not intended to cope with the problem that so-called severely

ill mental patients pose, which all too often involves some form of lawless behavior that people don't want to treat as badness or crime (*Ibid.*).[(153).]

Szasz never worked in public health care, he was always a teacher and a private psychotherapist. He accepted his patients if they fulfilled two premises: that they wanted to see him voluntarily and that they were financially autonomous (Cf. Wyatt, 2004, p. 82). Given that, in general, psychotics do not feel the desire to see a mental health professional but rather their relatives or the authorities request his intervention and, on the other hand, many of them are economically dependent on other people or institutions, Szasz did not see them, just as he did not see children.[154]Based on the ideas that I will present below, I dare to insinuate that, even in the case that some economically independent psychotic asked him for an appointment, Szasz would not have accepted to see him either.

Szasz apparently did not want to have experience with such patients, which casts serious doubts on his theories of psychosis. He could have simply acknowledged his ignorance and suggested, from theory, that psychosis is not a disease like any . Without

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(153) "Since I arrived in Syracuse in 1956, my private practice always occupied less than half the time [than previously]. Because of the way I worked, the problem posed to me never arose. Anyone who wanted to see me as a patient had to make an appointment and pay me personally. This excluded those who, in reality, did not want to visit a psychiatrist but were forced by others to do so, especially through legal coercion. My practice was not set up to deal with the problems presented by so-called seriously mentally ill patients, which often involve some kind of illegal behavior that people do not want to treat as wrongdoing or crime."

[154]Not , on several occasions Szasz compared the treatment offered to children with that given to adult psychotics.

However, he strongly asserted not only that schizophrenia was not a disease (since there was no scientific evidence to the contrary) but that it consisted of an erroneous way of reasoning and acting that ultimately depended on the will of the subject. Szasz never gave an alternative to the problem of psychosis except that the insane should be left alone and that, if they committed any crime against persons or their property, they should be judged like any other citizen without using the argument of "mental illness" in their defense, since, in that way, their responsibility would be hidden and, therefore, their individual freedom limited and their dignity as a human being annulled. In my opinion, it is clear that delusions, like dreams, belong to the person. Only he or she alone will be able to say something about them and give them some meaning (the psychotherapist would act, in any case, as a catalyst). This belonging, however, does not imply that the delirious person or the dreamer can stop or modify his or her thinking at will.

If we go back to his statements, it could be said that Szasz was inconsiderate or even frivolous towards psychotics. A journalist, referring to a question from psychiatrist Ronald Pies, asks him the following:

> What if [a] young man rocking back and forth in a pool of his own urine, responding to voices from a CIA computer that are instructing him to kill himself, you know to bring this young man into hospital against his wishes is not to bully him but to begin the process of restoring humanity. And I wonder whether in blaming people for their circumstances -often very catastrophic circumstances and behaviours- that you're denying their suffering (Mitchell, 2009).

This was Szasz's response:

> Well it's impossible to answer this kind of question because it is based on a story which already validates psychiatry. Now where is this man who is rocking back and forth in his own urine? I've never seen such a person in more than 50 years of psychiatry -where is he, how did he get there, who is he and how does a psychiatrist know that he is talking to the CIA? There is only one way he could know that, that's by the patient telling him and the patient tells you that the CIA is talking to him; let's assume if someone told me that I would tell him, well congratulations, you are a very important person. That's not against the law (*Ibid.*)[155].

From a strictly liberal point of view like Szasz's, it is perfectly legitimate to treat all adults as free and responsible for their thoughts and actions. The problem is that Szasz makes no exceptions to the rule: to be free, every physically healthy adult must be able to control his behavior and therefore be responsible for it. Unless it harms others, no one should interfere in his life. Thus, involuntary medical treatment or judicial exonerations and mitigations lack justification. However, every clinician who has dealt with psychotics knows that psychosis is itself an exception that, under certain circumstances, requires the application of exceptional measures. On the contrary, Szasz considers that the insane person, like any other , can

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(155) "Well, it's not possible to answer that kind of question because it's based on a psychiatrically validated story. But where is this man who is rocking back and forth in his own urine? I have never such a person in over fifty years of psychiatry, where is he, how did he get there, who is he, and how does a psychiatrist know he is talking to the CIA? There is only one way he could know, by the patient's statement that the CIA is talking to him. Suppose someone said something like that to me. I would reply: okay, congratulations, you are a very important person. That's not a crime.

If he appears unable to handle his delusions at will, he should be considered a liar and not a sick person:

> I believe viewing the schizophrenic as a liar would advance our understanding of schizophrenia. [It is the hallucinating person who produces the voices he hears. If, on balance, the voices would disturb him more than they please him, he would stop producing them. Similarly, if hallucinations were as disturbing for patients as psychiatrists say they are, patients would be eager to take the drugs that silence their "voices." However, many hallucinating persons refuse to take antipsychotic drugs voluntarily, preferring the company of their "voices" to the human voices available to them or to silence. [...] The patient feels alienated from his own thoughts. Why? Because he does not want to be responsible for them. Hiding behind the excuse of slavishly obeying a Higher Law, he declares: "I heard God's voice ordering me to kill my wife". Self-alienation enables the patient to reject responsibility for his behavior (Szasz, 1996, p. 130-133).[156]

Statements such as these provoke outrage in any clinician working with psychotics. I believe that, in part because of their radicalism, many authors have given the

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(156) "I believe that considering the schizophrenic as an impostor would improve our understanding of schizophrenia. [...] It is the person who hallucinates who produces the voices he hears. If, after all, the voices bothered him more than he liked them, he would stop producing them. Similarly, if hallucinations were as annoying to patients as psychiatrists say they are, they would be eager to take the drugs that would quiet their 'voices'. Yet many of those with hallucinations voluntarily refuse to take antipsychotic drugs and prefer the company of their 'voices' to that of the human voices at their disposal or that of silence. [...] The patient feels alienated by his thoughts. Why? Because he does not want to take responsibility for them. Under the excuse of obeying as a slave to a Superior Law, he affirms: 'I listened to the voice of God who ordered me to kill my wife'. Alienation itself allows the patient to reject responsibility for his behavior" (Szasz, 1996, p. 130-133).

I have either rejected Szasz or interpreted his work only in this light, disregarding its richness. While criticizing these opinions of Szasz, my intention is to go a little further:

Why did Szasz, a person known for his kindness and exquisite politeness in personal relationships, allow himself to say things like that? Szasz not ignorant, nor was he a provocative *enfant terrible*. From my point of view, he must have had a deep personal motivation that led him to hold such iconoclastic positions as those referred to above and for which he received both the harsh criticism of his enemies and the ignorance of those who could be his allies, the critical psychiatrists.

Szasz was, before being a psychiatrist, a liberal intellectual, and all his work is impregnated with this political ideology. As a defender of individual liberties, he abhorred and condemned the involuntary hospitalization and treatment of the "mentally ill." While his opposition to such practices was laudable, I suspect that he used his liberal ideology as a justification for not confronting the irrationality of the insane and the subjugation and dependency in which every hospitalized patient finds himself. I return for a moment to his biography to try to clarify my suspicion.

As I indicated, Szasz went to great lengths to avoid seeing involuntary psychiatric patients in his years as a psychiatric student. However, in his final year of residency at the *Institute for Juvenile Research*, he had to see "families and their troubled children in the outpatient clinic." Many of those "problem children" probably would not have wanted to visit Dr. Szasz. Later, as an Army psychiatrist, Szasz confesses to having had involuntary patients who were not hospitalized. Thus, Szasz did see, albeit under very particular circumstances (his need for professional accreditation and his obligation to the army), patients who did not wish to

see him. However, unlike any other physician or psychiatrist, he managed to avoid seeing hospitalized people and psychotics (he never said that the "problem children" at the *Institute for Juvenile Research* or the recruits at the *United States Naval Medical Center* at Bethesda were psychotic).

This leads me to contemplate the thesis, which I will not be able to prove as it is merely speculative, that Szasz did not find the involuntariness of psychiatric intervention as unbearable as the hospital environment in general and the irrationality of the madman in particular. Recall that Szasz did not want to be a practicing physician (a professional who at some point in his professional life, if not all of it, works in a hospital), he was only interested in theory. He decided, therefore, to become a psychoanalyst (a professional who can work exclusively in the private sphere and who "does not touch his patients"). To achieve this, he had to specialize in psychiatry but, as a resident, he refused to follow his superior's recommendation to complete his training in a hospital where seriously mentally ill patients were treated.

In his training, Szasz refused to treat hospitalized persons as a physician and insane persons as a psychiatrist, but he did not want to refuse to complete his psychiatric residency and his military service without attending involuntary patients. However isolated and perhaps minimal these facts may seem, they should be highlighted and not justified by a mere understanding of the specific circumstances (due institutional obligations), as Szasz was doing when he criticized his enemies. Finally, I again draw attention to what happened in the last days of his life: he broke a vertebra, which, probably, considering his advanced age and the severity of the damage, would leave him in a situation of physical dependence. He refused to be operated on (hospitalized) and decided to commit suicide. As I said when narrating these facts,

Szasz died in a manner consistent with his liberal beliefs, which is admirable. Now, if a broken vertebra is not a terminal situation, how much weight did the horror of heteronomy, of being hospitalized and cared for (touched) by others play in his fatal decision?

The point I want to make is that Szasz seems to have built a solid conceptual armature against the use of the term mental illness and the abuses of psychiatry as a protective shield against a personal rejection of the dependency to which any person hospitalized for physical or mental reasons is subjected. By virtue of such a defensive resource, Szasz refused to accept the idea that a person (the psychotic as the epitome of a structural irrationality) cannot control his or her thinking and cannot be held responsible for his or her actions. Szasz prefers to consider that the madman's delusion lacks logic and is the result of ignorance or malice.

I suspect that his perfectly admirable willingness not to treat people who did not want to be helped served as an alibi to avoid the anguish that can be provoked by the irrational discourse of the madman. Just as many biological psychiatrists disregard the psychotic as a hopeless moron who should not be paid much attention to, Szasz despises him as an impostor. In my opinion, both positions use denial as a defense against the anguish and bewilderment caused by madness.

I consider that Szasz's theories on severe mental disorders are as far from the understanding of these phenomena as are the organicist theories. For biological psychiatry, the psychotic is the victim of a brain dysfunction that confuses his thoughts and distances him from reality. At the opposite extreme, Szasz considers that any person, whatever his psychological state, can control his thoughts, by

irrational they may be, at will and, therefore, is always responsible for his actions. This quote from Szasz shows both positions: "The *APA* holds that pathological gambling [as an example of 'mental illness'] is an action that the patient *cannot control*; and that, generally, all psychiatric 'symptoms' are beyond the patient's control. I reject such a claim as patently false" (Szasz, 2001, p. 79). At stake here is the thorny issue of the madman's moral responsibility for his thoughts, feelings, and behaviors. Szasz does not admit that a person without a demonstrated neurological disease is not in charge of his or her actions, which is contrary to the observation of any professional who has worked with psychotics.

Quite different is the position of the critical psychiatrists referenced above, who are as opposed to the scientism of biological psychiatry as they are to Szasz's assumption of responsibility and reason by decree:

> Experiences such as hearing voices and fearfulness demand a more complex understanding than simply being seen as symptoms of an, as yet unidentified, abnormal brain process. However, often such experiences are phenomena that cannot be controlled by a simple act of will. We find the following statement from Szasz unconvincing: "I do not regard hallucinations and delusions as 'symptoms' requiring 'treatment.' I view hallucinations as disowned self-conversations and delusions as stubborn errors or lies. Both are created by 'patients,' and could be stopped by them".[157]This implies that such patients simply have to make a decision in relation to these phenomena for them to go away. Our encounters with many people who experience voices and/or delusions has convinced us that often these individuals are profoundly 'stuck' in a way of feeling, thinking, or behaving that involves all of these phenomena.

[157]Bracken and Thomas extract this quote from Szasz's response to Richard Bentall's article in the book *Szasz under fire* (Szasz, 2005b).

> the dimensions of their being. Suggesting that their problems can be solved by a simple act of will is to seriously misrepresent the reality of their suffering. Recognizing this does not commit us to a simplistic medical understanding of their experiences (Bracken and Thomas, 2010, pp. 222-223).

I agree with the opinion of Bracken and Thomas. In my view, biological scientism and Szasz's radical denialism represent two positions apparently opposed but united in their dogmatism. Neither can demonstrate the validity of their claims presented as unquestionable truths. The problem with dogmatic clinicians is that they tend to superimpose theories on what really happens in the patient's subjectivity, which makes it difficult to understand the case and to establish a therapeutic commitment.

5.2. A POLITICAL MISTAKE: ABOLISHING INSTITUTIONAL PSYCHIATRY

As I have just pointed out, Szasz's main theoretical mistake was to ignore the obvious exceptionality of psychosis. On the other hand, on the political level, his fundamental mistake was, in my opinion, to call for the abolition of institutional psychiatry and to oppose with equal force those who defended the psychiatric system prevailing in the 1960s as those who managed to reform it later and, in general, anyone working in public health care. The Szaszian ideal of a single private and contractual psychiatry is compatible neither with the very experience of psychosis nor with a democratic conception of the welfare . Institutional psychiatry will not disappear because it fulfills a social function, often difficult to justify, but necessary. Time has proven right

Szasz that psychiatry has little to do with medicine and has been removed so that it can disappear from society.

Szasz was left alone because of his proud abolitionist emphasis. In his radical drift Szasz missed the opportunity to make a valuable contribution to a sensible institutional psychiatry as proposed by critical psychiatrists. I believe, therefore, that Szasz was mistaken in his political strategy. As the prestigious professor he was, he should not have dedicated his interventions to saying that "all institutional psychiatry is coercive" (which puts psychiatrists working in public health on the defensive) but rather to generating a permanent critical spirit among psychiatrists that would eventually lead to what is known today as "critical psychiatry". Szasz should have fought with greater emphasis in his field, the philosophy of psychiatry, and let his students, practicing psychiatrists, fight politically in the hospital for a dignified psychiatry. However, he preferred political criticism to educational work. Not only did he fail to abolish institutional psychiatry, but even those psychiatrists who would share his principles consider him a radical and do not pay due attention to the substance of his thinking. Nevertheless, this thesis is a wake-up call to critical psychiatrists about Szasz's work as a pioneer of their current claims.

In this last epigraph, I would like to make an appeal to recover the multidisciplinary and critical spirit with which Szasz began his academic career in Syracuse until he came up against psychiatric power. We must recover rigorous and open-minded psychiatric studies as the best way to achieve the goal of a psychiatric practice consistent with the nature of the problems it treats and respectful of the human beings who suffer from their psychological disorders.

For decades, official psychiatry and clinical psychology have been proclaiming in universities, hospitals and that they are objective sciences. However, work with patients insistently demonstrates the opposite. Psychiatry is an epistemologically weak discipline in comparison with medicine since its *object* is ungraspable subjectivity, "an individuality that must always elude the methods science" (Sullivan, 1962, p. 62). This inconsistency as a science may be uncomfortable for the psychiatrist in justifying the meaning and usefulness of his or her work. Frequently, psychiatrists and psychologists envy the accuracy and concreteness with which physicians act and express themselves and try to combat the epistemological and conceptual disadvantages of their discipline by resorting to a scientistic discourse and praxis. The result is a clamorous reductionism that leads to systematic ignorance of human subjectivity in all its complexity. In my opinion, such a scientistic emphasis responds to a defensive attitude in the face of the uncomfortable ambiguities that psychiatrists face due to the epistemological weakness of their discipline. Sylvie Faure (1975) (and before her pioneers such as Foucault, Goffman and Szasz and, later, those I call "critical psychiatrists") pointed out such ambiguities in relation to the psychiatrist's performance as a physician in asylums, for that was the historical context in which she wrote the following words. These can be perfectly applied to the current way of thinking and acting of organicist psychiatrists (and experimental psychologists) in their research, academic training and professional practice in hospitals:

> The first ambiguity of the asylum physician is his place of action, which obliges him to represent in a coercive structure a repressive role disguised as a medical role, which falsifies in advance his therapeutic action. The second ambiguity is found in the request for care, since it does not emanate from the person concerned but from a third party. A third ambiguity appears in the medical character of the psychiatrist; this one and the training that is imposed make of madness a

illness that the subject would suffer from as he could suffer from a fracture [...]. Mental illness cannot be considered as an object of observation and experience, eventually reproducible under the same conditions and independent of the medical subject who examines it. [...] The use by physicians of an organicist system of thought is therefore not entirely satisfactory for psychiatrists, unable, however, because of their strictly medical training, to conceive of any other.

A fourth ambiguity of this uncomfortable psychiatric position stems from the radically specialized nature of the teaching, in which the equivalent of a physiology of the spirit is never contemplated. The young psychiatrist will learn the anatomy of the brain, but ignores the sciences of human relationships and behaviors.

The last of the major ambiguities appears when the doctor is confronted with the madman and no longer apologizes: authoritarian vigilance, mediatization by nurses, interest in intercurrent diseases once allowed doctors in asylums not to communicate with the madman but to objectify him, but from the moment he accepts today to face madness as a person, an intolerable anguish appears: this comes from the identification with his patient.

The deeply uncomfortable character of the psychiatrist's situation under the different aspects we have just contemplated leads to the incessant search for means of defense against the real confrontation of madness. [...] Some are simple material defenses that avoid dual contact, loosening of the pathology by drugs, "reification" of the subject who is transformed into a "beautiful case". Others are more elaborate, projection of responsibility on others (the administration, the political regime), use of theoretical knowledge, of a "knowledge" about the other that allows one to situate oneself at a stroke as different from him. [...] *Classical psychiatry* almost completely assumes the medical model [...] [which] in a diagnosis, a prognosis and a treatment. [...] Such a scientific attitude is accompanied by research in different domains ... Can we still hope one day to isolate any agent responsible for delirium, including neuroses and even character disorders? If biochemical anomalies may very well accompany these

> states (just as in the phenomenon of fear there is secretion of adrenaline), it is probable that these modifications are more the effects of psychic problems than their cause (Faure, 1975, pp. 8-15).

The ultimate element that distinguishes medical psychiatry from non-medical psychiatry is the different consideration of the symptom as a sign of an organic disease or of a psychosocial conflict. The biomedical model understands the symptom as something supervening on the patient and deriving from a biological event (for example, a chemical imbalance in the brain) that has to be localized and repaired. For them, that is the end of the problem. But there is clear evidence that the process of locating such a supposed cause does not follow a reliable method in scientific terms and that, if such an organic phenomenon exists, it could not alone explain the complexity of the psychological disorder. In spite of this, the biological psychiatrist, instead of questioning his theories and methods, reaffirms them and acts as a doctor making a diagnosis, a prognosis and a treatment that in no case is based on evidence as it happens in the rest of the specialties of medicine. In this way, the psychiatrist not only ignores the theoretical difficulty of the matter, but also the possible concurrence of personal and social factors that could affect the disorder and, thus, the global understanding of the problem affecting the patient. On the contrary, from a non-medical perspective of psychiatry, the symptom is the pathological representative of the existential conflict in which the patient is intimately involved. However painful it may be, the psychological symptom fulfills a function in the life of the person, which differentiates it from the medical symptom. It carries a message that must be understood (not merely described and classified) for which an indeterminate and unpredictable set of bio-psycho-social factors must be taken into account.

5.3. MEDICINE, PSYCHIATRY AND PSYCHOLOGY. THE TRAINING OF THE CLINICIANS

In psychiatry a longer time is needed than in medicine to understand the pathological process and to negotiate (not impose) a solution with the patient. Many psychiatrists do not allow themselves this time and, as physicians, try to fight the symptom directly (for example, with the exclusive use of medication) without taking into account that, due to its link with the subject's existence and its paradoxical function in his psychological system, it will be reinforced or will appear in a new form. In psychiatry, usually the diagnosis is hasty (i.e. based on the apparent signs but without understanding the possible origin and meaning of the signs), the prognosis is purely speculative and the treatment is haphazard and often has negative consequences. In this *medicalistic* process, where there is a rush to conclusion, the psychiatrist (or psychologist) considers the patient's verbal information irrelevant. This is how some of my patients explain it: A psychology student informs me that his professor said in class that "when I see a patient I don't want him to tell me about his life, that's a waste of time. I just want them to tell me what's wrong and I'll tell them how to fix it." A mother presents me with a report in which the psychologist who signs it diagnoses her seven-year-old son with ADHD. This diagnosis is based on the scores of the questionnaires administered to parents and teachers and on a large battery of *objective* tests that the child had to undergo. The psychologist presents the statistical data on which she bases her diagnostic conclusion but there is no record of her having spoken to the child or, therefore, of her knowing him. Two visits were enough to obtain the diagnosis and the recommendation to see a neuropediatrician to assess whether medication was necessary. One young man tells me that he had recently visited a very jovial psychiatrist who, after listening to him for a few minutes, said: "But

Man, you're too young to feel this bad just because your girlfriend dumped you! Take this (an antidepressant)". A woman has been visiting her psychiatrist for more than ten years, a very kind man who listens to her for a few minutes and gives her some fatherly advice or scolds her, as the case may be. Afterwards, they go to another room where he takes her pulse, listens to her with his stethoscope and examines her eyes with a flashlight. He then writes her prescriptions and bids her a kind farewell until the next visit.

These examples are not a caricature but a small selection of the usual attitudes of some psychiatrists and psychologists who do not want to listen or understand. In the absence of real medical evidence to explain the psychological disorder, the only way for a psychiatrist to understand what is happening to his patient is to listen to him for a long time, in many psychotherapy sessions. However, not everyone is willing to "waste their time" with psychotherapy or give up their prestige as physicians and scientists.

Psychotherapeutic work, in any of its modalities, consists of a verbal communication between two people about the life circumstances of one of them and a personal commitment between them to solve the problems. As Szasz pointed out in 1959, to say that psychotherapy is a form of medical treatment is scientifically indefensible and, moreover, there is no guarantee that a physician, just because he or she is a physician, is a competent psychotherapist (pp. 462-463). In psychotherapy it is not a matter of assuming the existence of a causal object (gene, hormone, neurotransmitter, brain area, etc.), but of interacting verbally with a human being in order to understand his particular position in the world, to locate those psychosocial factors that condition his discomfort and help him to

better living. No natural-scientific methodology is useful in such a personal exchange of information that is better linked to disciplines or arts such as ethics and rhetoric. For their part, advocates of an exclusive social etiology of psychological disorders, as was Szasz himself, would be wrong to disregard the possibility that factors of a biological nature not directly addressable in psychotherapeutic experience determine, to some degree, the psychological structure of the individual. I consider it as absurd to assert that every psychological disorder has an exclusively organic origin as that the biological has no influence on behavior. The presence of brain processes underlying certain disorders seems obvious to me; to deny it would be as much as to deny that we inhabit a body. But it must be recognized that neuropsychiatric research has not provided convincing evidence of the weight of such processes in psychological disorders.

Even if the existence of a certain organic etiology were considered plausible, or even demonstrated, the patient would still face existential problems derived from it that no pill can solve. In my experience as a clinician, I have not met a single person who has solved his or her psychological problems with the exclusive use of psychotropic drugs. I have met many for whom the use of such has caused serious side effects, both physical and psychological. On the contrary, a very large number of patients have solved their problems, often serious ones, thanks to psychotherapeutic work alone, and have even been able to stop taking medication thanks to it. I do not mean to say that medication, used prudently and sensibly, is not opportune and convenient in some cases, nor that it may be a necessary aid, but rather that there can be no resolution of psychological conflicts without psychotherapy. Therefore, unlike what happens in university studies and in public health care, psychotherapy should be

considered the primary resource in which clinicians should be trained and practiced, however, for decades and even today:

> Psychotherapy, in the neo-Kraepelinian view, should play a relatively secondary role in the treatment of mental disorders and perhaps be administered by auxiliary professionals, who would help patients cope with their problems until the medical treatment they were receiving took effect. Neuroscience was the discipline with the greatest relevance to psychiatry, while psychology and the social sciences were considered of secondary interest. Young psychiatrists were told that they should pay more attention to advances in molecular genetics than to talk therapies. As might be expected, the therapeutic relationship was relegated in importance. Clearly, psychiatrists were to be polite to their patients, but their healing was to be achieved by manipulating neurotransmitters, not by understanding and interpreting their thoughts and feelings (Bentall, 2011, pp. 166-167).

The scientistic and *medicalistic* "truths" in which psychiatry and psychology students are indoctrinated today condition their subsequent practice: "Young clinicians find themselves at a loss when confronted with ailments that are not present in the official lists. A common response, when faced with this situation, is to ignore the ailment or to make it fit within an official ailment" (Berrios, 2011, p. 37). Duncan Double denounces this situation for which our reductionist university education is primarily responsible:

> The lack of a whole-person way of understanding mental health problems originates in medical training. In particular, reductive causal analyses do not help to make intelligible the reasons for human action. Medical students are indoctrinated into a natural scientific perspective of basic biological processes. The issue is never raised about whether an understanding of human behaviour should take a form similar to the laws of natural science.

Despite the obvious failings of positivism, its attraction is that it seems to avoid the complexities and uncertainties of psychological and social perspectives. Taken to its extreme, such an approach becomes irrational.

Once imbued with the idea that experimental natural science is an adequate discourse for a description of personal behavior, medical students may take a mechanistic view of their treatment of patients. They are encouraged to see psychiatry as little different from medicine in this respect, although they do sense the uncertainties of mental health work and regard it as less rigorous and developed as a discipline. Still, the cause of a person's insane behavior or other mental health problems is their "chemical imbalance" or some other brain dysfunction, even if the mechanisms underlying this pathology seems less well understood than for other physical conditions.

The difficulty of communicating with disturbed and disturbing people can create defensive practice. Concentrating on the bodily complaints of people makes sense if they have a physical origin. Emotional complaints do not have to be addressed if they are reduced to their bodily substrate. Questions are avoided about why psychiatry interfaces with the law and human rights. An ethical approach to psychiatric practice can be difficult to sustain. The aim of social control may produce a lack of compassion and feeling in the care of people with mental disorder, and the history of psychiatry confirms the common degradation of patients. The health professional's own need for self importance can override the patient's problems.

These problems are not totally unique to psychiatric training. Much of the current criticism of medical professionalism is of an arrogance created because of the difficulties in engaging with people's suffering through illness. Claims are made for medical techniques which go beyond the evidence. Patients may have needless investigations and be overtreated. In an attempt to bolster professional interests, self-questioning is discouraged in the interests of certainty [...]

Contemporary critical psychiatry needs to be clear that the concept of mental illness can be applied to psychological dysfunction (Farrell 1979). The biological viewpoint is unjustifiable, as it assumes that mental illness is real in the physical sense (Double, n.d.).

Asserting psychiatry's medical identity without providing rigorous scientific evidence and thus justifying haphazard interventions that carry serious health risks is disingenuous, to say the least. As Szasz pointed out in the late 1950s and Bracken and Berrios, among many others, defend today:

> I believe that because psychiatry is tasked to deal specifically with problems of beliefs, feelings, behaviours and relationships, its knowledge has to be qualitatively different to that upon which a medicine of the tissues is built. [...] The current powers and responsibilities of psychiatry are not warranted on either empirical or philosophical grounds (Bracken, 2012, pp. 56-57).

> The *sui generis* epistemological condition marks the difference between psychiatry and other medical specialties. This difference should regulate the form of both teaching and research and practice. Unfortunately this is not the case, and often the teaching and research components of psychiatry are (erroneously) based on the customs of surgery or general medicine. From what we have said so far we can infer that only an integration between semantics and neurosciences can lead us to understand people's thinking about suffering from a "mental disorder" and thus the requested management strategies (Berrios, 2011, p. 32).

According to Germán Berrios, "as psychiatry is a hybrid discipline, it poses specific problems and, , it is not correct to try and import methods from other disciplines. For practicing psychiatrists, it is best to be trained in philosophy and epistemology" (*Op.cit.*, p. 34-35). This training that once existed, at least in the faculties of psychology, has long since disappeared. Someone must have considered that philosophy, ethics, anthropology, linguistics, sociology, etc., were not sufficiently "scientific" and, therefore, it was necessary to

to dispense with them in order to wear a white coat with dignity. However, it seems that something is changing and more and more professionals in psychology and psychiatry consider that "for psychiatry [and psychology] it will never be possible to discard the human sciences [...] only to depend on the "invariable" objects offered by the natural sciences (*Op.cit.*, p. 21). It would be desirable, for the sake of the disciplines of so-called "mental health", a change of academic and institutional direction that would allow dogmatic "truths" to give way to questioning, interrogation and critical thinking; where training programs would engage not so much in the task of classifying and treating but in that of understanding and helping the patient. This cannot be done by ignoring the humanities. Szasz would agree: "I believe that we can gain more insight into psychological distress from Shakespeare and Dostoevsky than from the Diagnostic and Statistical Manuals of the *American Psychiatric Association*" (Szasz, 2010, p. 230). Berrios and the rest of critical thinkers and practitioners are as well:

> Philosophizing may be something to be dispensed with, but it becomes mandatory in periods when one psychiatric ideology is allowed to predominate over all others and when this predominance seems to harm the understanding of mental disorders. Psychiatrists are becoming aware that the predominance of one ideology does not serve them well in treating patients, and the need to develop other approaches is being restricted by the predominant ideology (Berrios, 2011, p. 148).

As I showed in the first chapter, criticism of positivist and coercive psychiatry cost Szasz his position as a trainer of residents. A similar fate has befallen many other critics such as David Ingleby who, after the publication of his *Critical Psychiatry*, saw his imminent admission as professor at *Cambridge University* frustrated (Sedgwick, 1981) or David Healy, a prestigious psychopharmacologist very critical of the alliance between the

psychiatry and pharmaceutical companies, which met an identical end at the *University of Toronto* whose psychiatry department was funded by these corporations (Healy, 2002). History has shown that "mainstream psychiatry eliminates any challenge to orthodoxy [...] [and that] the questioning of the discipline itself is necessary in the training of psychiatrists" (Double, n.d.). Szasz was the first to rigorously question the foundations of psychiatry and to openly challenge its scientistic authoritarianism. He was also the first to suffer condemnation for such daring. I believe that, beyond their ideological differences, the new critical psychiatrists should recognize Thomas Szasz for his personal courage and his importance as a theorist.

In view of the above, I would like to make, in conclusion, a concrete proposal. From my point of view, it is useless to attack psychiatric power head-on, as Szasz did, given its strong links with political and economic powers. However, I would like to believe that the rigorous and permanent questioning of biological psychiatry will eventually lead to the predominance of the perspective defended by critical psychiatrists. Sooner or later, they will have to provide an answer to a fundamental dilemma which, since the origins of psychiatry, remains to be satisfactorily resolved: is psychiatry a medical specialty? Following the reasoning of the critics, the answer should be negative and psychiatry should disappear as we know it today, as just another branch of medicine. Currently, the most consistent theoretical model and the one that has the greatest acceptance among critics is that of the *Cambridge School*, which considers psychiatry a hybrid science between the natural sciences and the humanities, since its object, psychological disorder, has a mixed (bio-semantic) structure. On the other hand, if the distinctive practice of psychiatry, psychotherapy, is a type of human relationship different from the medical one (more similar to the one Socrates established with his pupils than the one Hippocrates established with his pupils), then psychiatry has a mixed (bio-semantic) structure.

their patients) that can be practiced with equal skill by psychiatrists and clinical psychologists, critical psychiatrists should question the separate existence of two professions dealing with the same problem: psychological suffering.

Consequently, the university training of future clinicians should be equally *hybrid*, independent of medical and psychological studies and fundamentally focused on the art of psychotherapy. In my opinion, specific university studies in psychiatry should created, comprising: a) basic training in psychobiology, psychopharmacology and neurosciences but also in history, sociology, linguistics and philosophy (especially anthropology, epistemology, logic, ethics and philosophy of science); and b) more specific training in the various psychotherapeutic orientations and not only in the so-called "scientific" ones endorsed by the evidence-based psychology and psychiatry *lobby* that today predominate in the university. Once this basic and specific training has been completed, the student would be in a better position to specialize in one of the psychotherapeutic schools (psychoanalysis, cognitive-behavioral, systemic, sexology, gestalt, etc.), if he/she so wishes. Studies of this type would place the new psychiatry in the intermediate and particular place which, because of its object of study, corresponds to it among the sciences. A multidisciplinary and non-dogmatic educational system that fosters a critical spirit and interest in constantly questioning theory and practice would offer the future clinician a broad cultural background that would allow him or her to develop with better resources and greater freedom in his or her future practice.

If, from this perspective (today utopian) the new psychiatrists (currently psychiatric physicians and clinical psychologists) would not be physicians, two crucial questions arise: in which public institution would they work? and who would prescribe the necessary psychotropic drugs in certain cases?

cases? My proposal, in line with the Cambridge model, is to create *hybrid* spaces halfway between a health center, an educational center and a social assistance center. In such places, doctors specializing in psychopharmacology (remember that Frances points out that 80% of psychotropic drugs are prescribed by general practitioners without specific training), nurses, social workers, educators and psychiatrists would work in close collaboration. Decisions as to how to treat each patient (or user) would be made by consensus and each would be employed in his or her professional competencies, which in the case of the physician would be to prescribe medication and in the case of the psychiatrist to practice psychotherapy. At the same time such places could be centers of postgraduate training.

I consider this academic and professional system, undoubtedly imperfect and susceptible to innumerable nuances, to be consistent with the theses defended by critical psychiatry. I believe that initiatives of this type are more likely to successfully combat the scientistic authoritarianism of biological psychiatry and the consequent medicalization of psychological disorders, i.e., the alarming, continuous, dangerous and perverse increase in psychiatric diagnoses and pharmacological treatments.

Finally, I would like to recall that it was Szasz who was the first to advocate multidisciplinary training for psychiatrists, the same that critical psychiatrists claim today. But, unlike Szasz, critical psychiatry timidly questions the affiliation of psychiatry to medicine when in its writings it presents all the arguments to conclude that such affiliation is not adequately justified. Being fully committed to the positions of critical psychiatrists, I consider that they should take a decisive and coherent step forward: beyond their university training in medicine,

should stop calling themselves physicians and limit themselves to the denomination of psychiatrists. They should strongly support the professional autonomy of psychiatry from medicine and the creation of a new university curriculum in line with the fundamentals of its science. In relation to this, just as the psychiatric reform of the 1970s and 1980s disassociated psychiatry from the insane asylum, the psychiatry of the 21st century should definitively disassociate itself from the general hospital. Not to undertake these or similar initiatives would be to go against the honesty that Szasz and critical psychiatrists claim for psychiatry.

This thesis has been intended as a contribution to the recovery of the scientific and professional dignity of my discipline. I trust that it will be useful in the debates that are already taking place and will encourage the initiation of others, such as those I have proposed here, which I consider unavoidable.

CONCLUSION

This doctoral thesis has vindicated the importance of Thomas Szasz's work in the history of psychiatry, specifically, as a predecessor of the trend called "critical psychiatry". The work was divided into two parts. In the first part, Szasz's biography and work were presented in order to clarify who this author was and what were the fundamental lines of his system of thought. In the second part we have tried to answer three questions: Was Szasz an anti-psychiatrist, do his theses coincide with those of current critical psychiatrists, and why do they not recognize him as a precursor?

In the first chapter a biographical study of Thomas Szasz has been carried out in which two facts have been highlighted. The first, the censure to which he was subjected at his university in 1962 for defending positions contrary to those of institutional psychiatry, basically, that the concept of mental illness is a myth, that psychiatry is not a science like medicine and that coercive psychiatric practices have no justification in a state governed by the rule of law. The second fact underlined is that Szasz always refused to treat institutionalized patients, specifically psychotic patients, which conditioned, in my view, his conceptions of the experience of insanity.

In the second chapter, the system of thought of Thomas Szasz has been presented, structured in three aspects: his conceptual and epistemological analysis of psychiatry, his political critique of psychiatric power and his conceptions of human behavior and psychotherapy. Special attention has been paid to the first facet by posing three fundamental questions: what is mental illness, what kind of science is psychiatry, and what kind of science is psychiatry.
should psychiatry follow a medical model? In summary, Szasz's conclusions are as follows

are: a) the term "mental illness" is a linguistic resource invented by psychiatrists to justify their medical status; b) given its object of study and intervention, psychiatry is a social science; and c) psychiatry must abandon all medical practice. Secondly, as a liberal ideologue, Szasz made a radical defense of individual freedom based on responsibility. He accused institutional psychiatry of engaging in practices that violated such principles, such as the involuntary confinement and treatment of persons stigmatized as mentally ill or the justification whereby, because of such alleged illness, persons who had committed crimes were exonerated from criminal responsibility. For Szasz, everyone has the right not to be molested unless he or she does not break the law and, on the other hand, alleged mental illness should not be used as an excuse for a person to avoid the consequences of his or her actions and desires. Szasz launched these accusations as an argument for calling for the complete abolition institutional psychiatry. Third, as a psychotherapist, Szasz described the practice he called "autonomous psychotherapy" as a way of implementing the ethics of autonomy and responsibility that he advocated as opposed to the ethic of care characteristic of medical therapies.

The third chapter was devoted to clarifying whether, as most writings claim, Szasz was an anti-psychiatrist, a prejudice which, in my opinion, has partly conditioned a biased interpretation of his work by other authors. The history of anti-psychiatry has been analyzed, Szasz's criticisms of this movement have been exposed and, finally, the main arguments of a current current that bears certain similarities with anti-psychiatry have been pointed out: postpsychiatry. has been concluded that Szasz was, like Michel Foucault and Erving Goffman, an involuntary inspirer of the movement.

antipsychiatry, a contextual phenomenon of the sixties, located in London and whose true promoters were, among others, Ronald Laing and David Cooper.

The fourth chapter addressed the fundamental question of this thesis: can Szasz be considered a precursor of critical psychiatry? The basic principles of this trend, of which the *Critical Psychiatry Network* association is representative, were analyzed, and Szasz's thinking on the philosophy of psychiatry was compared with that of three of the main authors critical of psychiatric positivism: David Ingleby, German Berrios and Allen Frances. It has been concluded that many of the assumptions of this current of thought were already exposed and defended by Szasz before and that, therefore, this author should be considered a precursor of the current critical psychiatry.

The question that arises next is why these authors hardly mention Szasz in their writings. Having failed to find concrete answers, the fifth chapter has raised some assumptions that shape my particular critique of Szasz. Among his many successes, Szasz's great mistake was to oppose biomedical belief in "mental illness" with a fanatical conviction to the contrary, which led him to assert that all mental disorder is nothing but a fallacy and that every person, regardless of his circumstances, including the most severe psychosis, is always capable of controlling his thinking and is therefore responsible for his actions. Both positions are, in my opinion, two sides of the same coin since, clinging to their dogmas, they are incapable of demonstrating the veracity of their theories, which distances them from the reality we clinicians face on a daily basis. Given the epistemological inconsistency of psychiatry and the inapprehensibility of the experience of psychological suffering, I consider a non-dogmatic and open position to be more appropriate.

that questions prevail over any generalist and insufficient answer, a pragmatic and committed position with those who suffer the painful experience of psychological distress, an ethical position such as the one maintained, as shown in this work, by today's critical psychiatrists. Another fundamental error of Szasz was to seek the abolition of institutional psychiatry. I consider that the disregard for the insane and the abolitionism defended by Szasz had a personal and ideological motivation in him and have provoked the rejection of those who could have been his allies, the critical psychiatrists.

Finally, in agreement with both Szasz and critical psychiatrists, a call has been made to recover the scientific honesty that psychiatry and clinical psychology have been losing because of the prevailing scientistic reductionism in these disciplines. In my opinion, this task must begin with the development of a university curriculum for future clinicians, independent of that currently offered in medical and psychology faculties, in keeping with the particularities of these sciences and their practice, offering training that includes the humanities, ensuring the teaching of the various psychotherapeutic methods (and not only the so-called "scientific-medical" ones) that are available to the clinician and, ultimately, fostering critical thinking. In relation to the above, the creation of multidisciplinary spaces where psychiatrists would limit themselves to practicing what distinguishes them from other professionals, psychotherapy, has been suggested.

Finally, two questions have been raised that remain to be resolved and that I consider inescapable, from a critical point of view, for the future of our science: is psychiatry a medical specialty, and does the existence of two disciplines as similar as psychiatry and clinical psychology make sense? Thomas Szasz's answer to both

The answer to my questions was a resounding "no". I hope this research will encourage so-called mental health professionals, especially those I have termed critical psychiatrists, to debate these dilemmas with rigor and honesty.

ANNEX I

COMPLETE WORKS OF THOMAS S. SZASZ[158]

1947a. Szasz, T.S. 1947. The "Schemm Regime" in the Treatment of Extreme Congestive Heart Failure: A Case Report. With S. Elgart. *Ohio State Medical Journal*, 43 (September), 926-928.

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[158]Source: *Thomas S. Szasz Cybercenter for Liberty and Responsibility.* (Schaler (Ed.), n.d.) (http://www.szasz.com/publist.html). Revised and expanded by the author of this thesis.

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ANNEX II

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